

REPORT

Centre for  
Mental Health



# Maternal mental health during a pandemic

A rapid evidence review of Covid-19's impact

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An executive summary of this report can be accessed at:

[www.centreformentalhealth.org.uk/publications/maternal-mental-health-during-pandemic](http://www.centreformentalhealth.org.uk/publications/maternal-mental-health-during-pandemic)

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# 1. Introduction

At some point during the perinatal period (from pregnancy through to 12 months following childbirth), around 10-20% of women are affected by perinatal mental health difficulties (Khan, 2015). They can be affected by a range of problems such as antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis. These can occur quickly and can range from mild to severe.

Research indicates that up to 15% of women suffer from perinatal depression and anxiety (O'Hara and Swain, 1996; Heron, 2004; Bauer *et al.*, 2014). A barrier to seeking help can be stigma surrounding perinatal mental illness, fear of looking like an “incompetent” mother and, at worst, their baby being “taken away” (Edwards and Timmons, 2005; Krumm and Becker, 2006; Davies and Allen, 2007).

If not addressed or treated, perinatal mental health difficulties can result in poor outcomes for the mother and her transition to motherhood, negatively impacting the care she provides for her baby (Joint Commissioning Panel for Mental Health, 2012). In the long term, poor perinatal mental health can lead to poorer cognitive, emotional, social, educational, behavioural and physical development of infants (Sutter-Dalley *et al.*, 2011; Khan, 2015). It can also have detrimental effects on a woman's relationship with her partner (Chew and Graham, 2008).

Furthermore, if a mother is suffering from serious perinatal mental ill-health there is a greater risk of suicide, which is a leading cause of maternal death (Oates and Cantwell, 2011). Oates and Cantwell's (2011) evidence review found that nearly all maternal deaths due to psychiatric health problems were among women not under the care of specialist perinatal mental health services. Reporting on factors

associated with all maternal deaths between 2016-2018, MBRRACE found that 35% of the women who died had mental health problems, often alongside physical health problems and difficult life circumstances:

*“... These women should be regarded as extremely vulnerable as their ability to comply with treatment may be compromised...”*  
(Knight *et al.*, 2020b, page 42)

As well as the significant human cost of untreated perinatal mental health issues, it comes with costs to society, including the risk of poor child mental health outcomes. The cost of poor perinatal mental health is £8.1 billion for each year's birth cohort, equating to approximately £10,000 per birth (Bauer *et al.*, 2014; NHS England, 2016). In the Five Year Forward View, NHS England pledged to support no fewer than 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period (NHS England, 2016). NHS England pledged £365 million in investment between 2015/16 and 2020/21 to help this happen. This included access to specialist inpatient and community care along with psychological therapies (NHS England, 2016).

Access to specialist services and training, for GPs, other primary care staff, midwives, health visitors and maternity services (Joint Commissioning Panel for Mental Health, 2012) can lead to early identification. This in turn can lead to early intervention and a reduction in inpatient admission (Hogg, 2013) and maternal death. Specialist services can provide psychoeducation which increases mental health awareness, and can offer advice for long term management, improving quality of life for mothers and families (National Collaborating Centre for Mental Health, 2018).

## 2. Purpose and approach

### This review

The Maternal Mental Health Alliance applied successfully for special Covid-19 targeted funding from Comic Relief to commission Centre for Mental Health to conduct a rapid evidence review.

### Key questions of this review

- How has Covid-19 impacted on the mental health of expectant mothers and mothers of newborns?
- What has the impact of Covid-19 been on maternal mental health and perinatal mental health services, including voluntary and community sector, across all four UK nations?
- Where is there data available (or indeed gaps) on impact for the wider family, of which expectant mothers and mothers of newborns are a part? For instance, babies and partners.

### Methodology

#### A rapid literature review

We undertook a review of existing published and grey literature<sup>1</sup> about the impact of Covid-19 on maternal mental health and perinatal mental health services, including within the voluntary and community sector, across all four nations of the UK.

#### Review of freely available national datasets on perinatal mental health

We sought data on services and service use. In the event, only English data was available free of charge to the public. Figures referenced in this report cover perinatal mental health services for a period from October 2019 to September 2020. This is briefly discussed in the literature review section and a summary of all available data can be found in the appendices.

### Survey

We conducted an online survey with representatives of the voluntary and community sector across the four nations, reviewing how the sector had been impacted by Covid-19.

### Evidence submissions

We put out a call for evidence for written submissions, provided three verbal evidence-giving events, and additionally held two stakeholders interviews. In total over 60 organisations provided evidence. The call for evidence was circulated widely amongst relevant institutes and professional bodies (e.g. the Royal Colleges), amongst voluntary and community sector organisations in the sector, amongst commissioners and across the Maternal Mental Health Alliance and Centre for Mental Health networks.

### Limitations

Centre for Mental Health and Maternal Mental Health Alliance agreed not to specifically focus on collecting data directly from women who were pregnant or had recently given birth. This decision was taken as several other projects had collected such data and we were concerned that further surveying of such women might provoke difficulties and even retraumatise those who had, or still were, experiencing mental health difficulties during this current crisis.

Like any review, we were limited to the available evidence. Much of the literature on maternal mental health and this pandemic has been rapidly produced and is either not peer reviewed or has had rapid peer reviews.

There will be lessons yet to be learned from the crisis and some of these will only be after a period of reflection; this crisis is far from over and some of the best evidence is yet to be produced. There are several research and

<sup>1</sup> Grey literature covers a range of non-peer reviewed literature, sometimes unpublished.

review projects that coincided with our review, and which might have been informative, but they are yet to publish or have published after our data collection. Similarly, with our written and verbal evidence submissions, whilst we attempted to widely circulate our call for evidence, we are limited to those voices that came forward. There are gaps in views; one example is on mother and baby units and how they were accessed and operated over this crisis. However, national dataset for England provides data on these units and we mention this in the literature review section and in the appendices.

We received quite a lot of evidence on health visiting but less on other professional groups.

The evidence we received on the impact on fathers' and partners' mental wellbeing appears very limited, and this may need further exploration in its own right, including how their wellbeing can impact on expectant or new mothers' mental health (and vice versa).

This report refers to the direct impact on infants, but not as a central focus (which would risk repeating work already looking specifically at this area). Our strong recommendation is for this report to be looked at alongside the recent Parent-Infant Foundation report (Reed & Parish, 2021), as well as the *Babies in Lockdown* report (Best Beginnings, Home-Start UK and the Parent-Infant Foundation, 2020) for a fuller picture of how the crisis is impacting on babies as well as parents.

### 3. Literature Review

#### Covid-19's impact on women, maternal mental health and perinatal mental health

The Covid-19 pandemic has been found to disproportionately affect women, who are more vulnerable than men to socioeconomic inequalities, gender inequalities, domestic violence and economic insecurity (Robertson *et al.*, 2020; WHO, 2020). Additionally, women face challenges to their sexual and reproductive health rights (Robertson *et al.*, 2020; WHO, 2020). Further, women may be less likely than men to enjoy wage protection, job security, sickness pay or maternity leave given that an estimated 61% of people working in the informal economy are women (Bhan *et al.*, 2020). Jacob *et al.* (2020) highlight that these factors 'threaten to undermine globally the future population's physical and mental health and economic resilience', and recommend governments invest more resources in maternal, neonatal and child health. There is evidence that doing so would bring medium- to long-term health benefits for women, children and their communities, for example by improving their wellbeing and resilience. Investment in maternal, neonatal and child health also brings significant short-term benefits, such as reducing maternal mortality, child deaths, and stillbirths (Stenberg *et al.*, 2014).

In addition, the impact of Covid-19 on women may be neglected by existing measures. Commonly, the impact of lockdown on countries is explained in terms of reductions to Gross Domestic Product (GDP). This does not capture the impact on maternal, neonatal and child health because GDP does not include unpaid work. This relates to work that is primarily carried out by women: breastfeeding, childcare, care of the elderly and domestic work (Jacob *et al.*, 2020). The significance of assistance with domestic work is indicated by data from the Covid-19 New Mum Study; mothers who felt household chores have become more equally divided coped better with the pandemic (UCL, 2020). This surveyed mothers currently living in the UK with an infant aged up to 12 months.

Covid-19, and the restrictions and social distancing measures which have accompanied it, have created many new challenges and difficulties for pregnant women and parents of young infants. These include limited or no access to support from extended family, restricted access to primary health care and mental health services, job insecurity and unemployment, socio-economic pressures, and bereavement (Brown, 2020; Caparros-Gonzalez and Alderdice, 2020). For parents of school-age children, there has been the added responsibility of home schooling at certain points of the pandemic.

This literature review explores this impact, considering different groups of new mothers and expectant mothers. It is important to note that they are not one homogenous group, and that some women will encounter cumulative social and economic stresses during the pandemic, including poverty, racism, stigma and interpersonal violence (Howard and Khalifeh, 2020). This review also considers health practitioners' perspectives on the impact of Covid-19 on the women they support, particularly home visitors and mental health care staff, for which most survey data was available.

#### The impact on parents

Over 5,000 parents were surveyed by Best Beginnings, Home-Start UK, and the Parent-Infant Foundation (2020). The majority of respondents were parents of a baby aged 24 months or under. This survey was disseminated across the four nations of the UK with the support of the Maternal Mental Health Alliance.

Regarding the mental health impact of Covid-19 on parents, 6 out of 10 (61%) respondents shared significant concerns about their mental health (Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, 2020). Parents' confidence in being able to find suitable mental health support for themselves was low – only one third (32%) of parents were confident that they could find help for their mental health if they needed it. The data indicated that the need

for help was greater once the baby was born. A quarter (24%) of pregnant respondents who cited mental health as a main concern said they would like help with this, which was true for almost a third (32%) of those with a baby. Those completing the survey were largely white (93%).

A recent survey by Mind (2020) highlighted the range of difficulties parents face during the lockdown period. The majority of parents who answered the survey were women (78%). Most of the parents were white (95%). The majority of parents (77%) had personal experience of mental health problems and just under a third (31%) had long-term health problems or a learning difficulty or disability.

A notable finding (Mind, 2020) was that parents with children under 18 are more likely to be concerned about their financial situation (53% versus 43% of participants without children) and work (60% vs 51% of participants without children). In addition, over a third (35%) of parents reported facing difficulty in accessing mental health support due to balancing this with new additional responsibilities (vs 4% of participants without children), for example, one parent commented: “Because the children take up all my time I didn't have the opportunity or the energy to access any help”.

While the survey by Mind did not directly ask about the mental health of pregnant women or parents of newborn babies, it emerged from free text responses that lockdown was particularly difficult for new and soon-to-be parents. This related to parents lacking their usual support network of family and friends and face-to-face contact from the professionals providing support during the perinatal period. Respondents worried about how they would cope with the lack of social support after their baby is born. Women who had given birth during the pandemic reported anxiety about their baby's wellbeing and the difficulties of having only limited access to seeing their partners while they were in the hospital.

## Parents' concerns about the impact on their babies

Parents surveyed by Best Beginnings, Home-Start UK, and the Parent-Infant Foundation (2020) reported concern over changes in their babies' behaviour during lockdown. Almost half (47%) of respondents felt that their baby had become more clingy than usual and a quarter (26%) thought their baby had been crying more or having more tantrums. Parents on the lowest incomes reported this at a rate twice as high as parents on the highest incomes. Younger parents (25 and under) also reported that their babies were crying and being more clingy than usual at a higher rate than older parents.

A third (34%) of respondents believed that their baby's interaction with them had changed during the lockdown period.

It is worth noting that the virus is likely to have increased maternal anxiety to protect their infants, in a society where mums are disproportionately seen as responsible for keeping children safe and blamed if they are perceived to fail to do so (Das, 2019).

A survey of mothers and some partners conducted in Wales during the Covid restrictions reported that 90% (N=18) of mothers who had given birth during this period felt isolated (written evidence submission from the Office of Bethan Sayed MS).

Other research, however, has drawn attention to some perceived benefits of greater time with children in the early years. As part of a mixed methods study on public attitudes to the early years 0-5, a survey was conducted with 1,000 parents during October 2020 (IPSOS MORI and Royal Foundation, 2020). The findings included that few parents of children aged 0-5 (11%) thought that the Covid-19 pandemic would have a negative impact on the brain and mind development of their child. Parents' main concerns were that their children lacked the ability to socialise with other children (88%), other adults (56%) and would spend

too much time inside (56%). It is also notable that 44% of parents thought that their child's brain development would be better due to the pandemic, on account of increased time parents were able to spend learning (73%), playing (68%) and talking (65%) with their child. Parents whose working hours were reduced since the pandemic started were more likely to think that their child's development will improve than other parents (47% vs 40%).

Most parents (63%) reported that they have been able to spend more quality time with their child over the period of the Covid-19 pandemic to date. However, parents who have experienced financial difficulties during lockdown or who did not live with a partner were more likely to say they have spent less quality time with their child since the start of lockdown (13% and 16% respectively compared with 9% average).

## The impact on pregnant women

Berthelot's recent study (2020) found that pregnant women assessed during the Covid-19 pandemic reported more distress and mental health problems than pregnant women assessed before the pandemic. Two large and demographically similar cohorts of pregnant women from Quebec, Canada completed validated self-report measures. One cohort was assessed before the pandemic and the other cohort during the pandemic. After controlling for age, gestational age, household income, education and lifetime psychiatric disorders, women from the Covid-19 cohort were more likely than pre-Covid-19 women to present clinically significant levels of depressive and anxiety symptoms. Prenatal maternal distress can negatively impact the course of pregnancy, fetal development, offspring development, and later psychopathologies; therefore, the increased symptoms in pregnant women signify the need for more support for pregnant women during the pandemic. It is worth noting that most women in the sample had post-high-school training, and over eight in ten (85%) were financially well-resourced. This emphasises the negative impact Covid-19 can have, even on socioeconomically privileged women with low-risk pregnancies.

It is worth noting that concerns and worry can also filter down to young people with a pregnant mother. In a survey of young people during the lockdown by Childline (2020), feeling worried about relatives contracting the virus – particularly more vulnerable family members – was found to be an important issue affecting young people's wellbeing.

## Women and families at risk of poorer outcomes

Best Beginnings, Home-Start UK and the Parent-Infant Foundation (2020) surveyed parents about their experiences looking after a baby during the first lockdown. It emerged from the data that families already at risk of poorer outcomes have suffered the most – namely, families on lower incomes, from communities experiencing racial inequality, and young parents. 7% of the sample were from these communities and 10% of surveyed parents had a household income of less than £16,000.

The report also found that Covid-19 is likely to have widened the deep inequalities in the early experiences and life chances of children across the UK. Almost 9 in 10 (87%) parents were more anxious as a result of Covid-19 and the lockdown. There was a variation amongst respondents who reported feeling "a lot" more anxious: white (42%), Black/Black British (46%), Asian/Asian British (50%), parents 25 years old or under (54%), and parents with a household income of less than £16k (55%). With regards to parents working on the frontline, almost half (46%) of NHS, social care or other health care staff who were pregnant or had young children were concerned about their safety at work during Covid-19. They reported feeling let down and unprotected at work, and this theme was particularly strong from parents of colour.

Das (2020a) carried out in-depth qualitative interviews with 14 women across England which highlighted how Covid-19 impacts perinatal mental health disproportionately. Although it was a small sample size, the data offers rich insight into the experiences of mothers during this time. Nearly half of interviewees had diagnosed mental health difficulties. Most

interviewees had a baby between 1-4 months and three were pregnant, in the third trimester. There was a wide variation in the women's awareness of digital support. The case studies included illuminate the different pressures women can face during the pandemic.

For example, Das interviewed an Asian woman who had a newborn baby. Her husband was under great pressure to keep working certain hours each week in order to meet a migration requirement (Das, 2020b). This meant she had less help raising her newborn baby and carrying out domestic work. She experienced pressure from her parents-in-law, who told her she ought to never leave the house, even for a walk, so her baby would stand no chance of catching Covid-19. As a result, the woman stayed in her home for 7 weeks with her newborn without leaving the house at all and would sit looking out of the window. This pressure can be understood in the context of living in a culture where women may be seen as fully responsible for keeping infants and children safe, even at the expense of their own mental health, and may be blamed harshly if they are perceived not to do this (Das, 2019). In addition, the interviewee had no awareness of digital support services she could have accessed, such as IAPT, and so was completely cut off from support at what was already a challenging time looking after a new infant (Das, 2020b). Therefore, it should not be assumed that most women are aware of the digital services on offer; many women are left behind.

## The impact on working mothers

Pregnant Then Screwed (2020a) surveyed 19,950 mothers and pregnant women from 16-18 July 2020, mainly focusing on the impact of a lack of childcare provision during the Covid-19 pandemic. Of the employed mothers who answered the survey, four out of five (81%) said they need childcare to be able to work, and over half (51%) reported not having the necessary childcare in place to enable them to do their job. Almost three-quarters (72%) of mothers said they had to work fewer hours because of childcare issues. The lack of childcare was a significant challenge for mothers, and 65% of mothers reported having been furloughed from their jobs on account of their lack of childcare.

Regarding expectant mothers, one in ten (11%) of pregnant women said they had been made redundant, or expect to be made redundant, during the pandemic. Over half (53%) of pregnant women who were made redundant believe their pregnancy was a factor in the decision. Of pregnant women of colour who were made redundant, over two-thirds (67%) believe their pregnancy was a factor in their redundancy decision. Regarding self-employed mothers, three-quarters (74%) reported that lacking access to childcare because of school and childcare facilities closing had reduced their self-employed earning potential.

Pregnant women are classed in the 'clinically vulnerable' category by the Government. Yet data from the survey showed that nearly half (45%) of pregnant women working outside of the home did not have an individual risk assessment conducted, which increased to 52% for pregnant women of colour. Almost half (46%) of pregnant women working outside the home did not feel safe from Covid-19 when they were at work, increasing to 59% for pregnant women of colour. In addition, the early stages of the Covid-19 New Mum Study found that mothers who travelled to work had significantly worse mental health than those who did not (UCL, 2020).

## The impact on pregnant women who are admitted to hospital with Covid-19

A national population-based cohort study in the UK (Knight *et al.*, 2020a) focused on pregnant women admitted to hospital with coronavirus in the UK. It found that most pregnant women admitted to hospital with the infection were in the late second or third trimester. More than half of pregnant women admitted to hospital with coronavirus in pregnancy were women of colour, 70% were overweight or obese and 40% were aged 35 or over. Knight *et al.* state that the significant number of women from these communities admitted to hospital with the infection warrants investigation.

The cohort study also found that one in ten pregnant women admitted to hospital in the UK with Covid-19 needed respiratory support in a critical care setting. Tragically, one in 100 of these women admitted to hospital with

the infection died. Overall, most women had good outcomes, and it was uncommon for the infection to be passed on from the mother to her infant(s) (Knight *et al.*, 2020a).

A report on maternity deaths in the context of Covid-19 from the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) found that 10 pregnant women died from Covid-19 between 1 March and 31 March 2020 (Knight *et al.*, 2020b). All of the women were in the third trimester of pregnancy and seven of the women (88%) were from diverse ethnic communities. Very few of these women had pre-existing diabetes, hypertension or cardiac disease. The disparity in outcomes of Covid-19 for people from diverse ethnic communities, as opposed to white people, clearly must be urgently addressed.

Knight *et al.* (2020b) found that changes to service provision on account of the pandemic meant that women were not able to access appropriate mental health care. The report added that receiving the specialist care they needed might have prevented the deaths of four women by suicide during the 3-month period. Knight *et al.* (2020b) emphasise that perinatal mental health care is as essential as other aspects of maternity care. During lockdown, women continue to be seen face-to-face in maternity services for investigations such as ultrasound scans and routine antenatal appointments. Face-to-face mental health assessments should also be necessary in some circumstances, for example when women request face-to-face contact or when there is a clinical need following a perinatal mental health risk assessment. The report recommends that triage via video or telephone consultations is used to identify women who need further face-to-face mental health care. The report states that the lead mental health obstetrician or midwife has a key role in triage and clinical review, particularly if there are repeated concerns about a woman's mental health.

Reported increases in abuse, exploitation and violence (Usher *et al.*, 2020) during the pandemic are associated with adverse maternal and child outcomes (Oram *et al.*, 2017). Knight and colleagues emphasised the need to develop

therapeutic relationships to enable women to seek support (2020b):

*“Both these women needed safeguarding. Whilst the first woman had multiple problems and had disengaged with services, all conversations were around protection of the child rather than the woman herself. Professionals should never give up trying to develop therapeutic relationships that will enable those subject to abuse to seek support.”*

## The impact on mental health of maternal choices and the services received

Make Birth Better is a group of experts who bring together lived experience and professional knowledge of birth trauma and vicarious trauma. It should be noted that before the pandemic, research found that a quarter of mums reported finding some aspect of their birth traumatic and that professionals felt overworked and exhausted, causing them to feel unable to support women in the way they wanted. The latter put mothers at risk of suffering from vicarious trauma (Make Birth Better, 2020).

From 8 April 2020-1 July 2020, Make Birth Better surveyed 485 expectant parents from across the UK about their maternity choices during the Covid-19 health crisis (Make Birth Better, 2020). Most women who completed this survey lived in the South of England or Scotland. Over one third (35%) of respondents were expecting their first baby. Most of the respondents (65%) had given birth before, and almost four in ten (37%) of these respondents had experienced a previous traumatic birth.

This report drew attention to the following challenges pregnant women faced:

- Fewer face-to-face appointments
- Loss of continuity of care – appointments being cancelled rather than an online/ phone one offered instead
- Suspension of maternity services and less support with breast feeding
- Less access to pain relief and maternal request caesareans

- Restrictions for birthing partners to attend antenatal appointments. Pregnant women reported it was difficult to process information and make decisions on their own, and to not have support from if there was difficult news
- Birth partners being unable to support women during labour due to Covid-19 restrictions. A survey (Pregnant Then Screwed, 2020b) of over 4,000 pregnant women who gave birth in October and November 2020 also found that 7% of those giving birth in a hospital (excluding induction or elective C-section) had to give birth without their partner present.

Key findings included that 90% of mothers reported their maternity choices changed and over half (51%) of women had to change their birth plan. A thematic analysis of responses to open-ended questions identified a sense of grief and sadness at losing the idea of the birth they hoped to have. One expectant mother reported:

*“We feel that our choices have been taken away from us, and that at a time when we should be excited and getting ready to have our babies, and looking forward to meeting them, we are consumed by huge levels of anxiety, stress and uncertainty.”*

Some respondents reported feeling forced into making changes to their birth plan or place of birth. Some felt the lack of choice “violate[s] women’s rights”. For example, one woman said she felt “unhappy and anxious – it further limits the choice I have, so if my trust decide I cannot have a C-section, I pretty much have to do what they want”. Some respondents expressed a desire to be better informed on the options available to them and able to discuss these, “rather than being told this is your only option when that is not the case”.

Another theme which emerged was respondents’ acknowledgement of the necessity of the restrictions, to protect staff and other birthing women. Yet, respondents expressed concern for their mental health, and that of other birthing women, and the need for emotional support – especially for those who had previously suffered perinatal trauma or mental health difficulties.

*“My fear is that I will look back in sorrow at what we had to endure during this time. I think the trauma will be lasting and far reaching!”*

Regarding mental health support, just under half (47%) of all women who reported being seen by a specialist mental health midwife reported that their support stopped on account of Covid-19 disruption. This was more frequently reported by first-time mothers. Just over half (53%) of women had continued to receive support from a specialist mental health midwife.

Furthermore, figures published by NHS England (2020) are indicative of a possible decrease in new and expectant mothers being referred to specialist perinatal mental health services. Whilst yearly figures indicate that the number of mothers in contact with specialist perinatal mental health services is steadily increasing, from January to April 2020, a sudden decline in referrals to perinatal mental health teams was observed in England. Notably, during the same period there was an upward trend in attended contacts. The finding that women experienced fewer face-to-face contacts might be indicative of services moving to alternative modes of communication such as video-conferencing, which would account for the upward trend in attended contacts. Furthermore, there appears to have been a decrease in the number of mothers spending time in a Mother and Baby Unit in the first reporting. Prior to this dip, a gradual increase in mothers spending time in these specialist units was observed. (See the appendices for further details on NHS England figures for mothers accessing perinatal and secondary mental health care).

A further difficulty reported by respondents was that information about maternity services was often unclear and hard to find, which was stressful and anxiety-provoking. The most frequently reported methods of communication were via social media pages or over the phone. Many of the responses indicated that the expectant mother took the initiative to ask questions or to find out information about any changes themselves, rather than being contacted directly by the service. Mirroring this finding, the survey by Best Beginnings, Home-Start UK, and the Parent-Infant Foundation (2020) found that in the antenatal period, over

one third (38%) of pregnant respondents were concerned about getting reliable pregnancy information and advice. It should be noted that the respondents with the lowest income felt less equipped with the information they needed during and after pregnancy, compared with those with the highest income. Fewer Asian/British Asian and Black/Black British respondents felt they had the information they needed during pregnancy or after birth compared to white respondents.

Disruption to traditional methods of professional advice continued in the postnatal period, where only 1 in 10 parents (11%) of under-twos had seen a health visitor face-to-face (Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, 2020). Further, nearly 3 in 10 respondents (28%) who were breastfeeding reported they had not had the support they required. Although some respondents valued digital health appointments, they left others feeling exposed and humiliated – exemplified by a case where a mother was “asked to send an email containing photos of my vagina and perineum to a generic GP practice email address to ensure I could receive antibiotics for the infection” which “felt completely wrong, a complete invasion of my privacy” (Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, 2020).

Much of the above is reflected in the ESMI research team submission (ESMI, 2020) to the House of Lords Covid-19 Committee on the ‘rapidly increasing reliance of digital technology’ during the pandemic, which concluded its evidence collection in December 2020 (UK Parliament, 2020). ESMI, who conducted interviews with 127 women, reported that whilst face-to-face contact was preferable for women in high-risk groups, digital and especially video technology (a preference for many women they spoke to) was often preferable for women who had many appointments linked to their pregnancy and found it difficult to attend them all. Such technology could also overcome women’s stigma concerning mental health, avoiding the necessity of visiting a mental health clinic or having a mental health professional come into their home. However, such platforms could also increase isolation and

impede in the development of therapeutic relationships. Additionally, like many issues during pregnancy, discussions around mental wellbeing require privacy which not all women will have when using digital technology.

## **The impact on services and women, from the perspective of health visitors**

A study by Conti and Dow (2020) explored the pressures on the health visiting workforce in the UK caused by the pandemic and lockdown. The authors point out that these pressures were made worse by the context of years of cuts to public health budgets which had weakened the health visiting service.

Survey data was collected from health visitors in the UK between 19 June and 21 July 2020. Respondents were primarily female (98%) and White British or Irish (88%). The survey findings highlight the widespread redeployment of health visiting staff<sup>2</sup>, which meant that almost two in five (38%) of the respondents saw an increase in their caseloads from 19 March to 3 June. Over a third (35%) of respondents who continued to deliver some face-to-face visits during the lockdown reported that they did not have suitable Personal Protective Equipment (PPE) at some point from 19 March to 3 June. The pandemic had negatively impacted staff wellbeing, with over two thirds (67%) of respondents reporting that their stress levels at work increased over the past year. A cause for concern was that, of the respondents who reported higher stress levels, more than a third (36%) said that they would leave health visiting if they could.

Due to respondents’ decrease in face-to-face contacts and increased caseload sizes, they expressed concern that parental mental health conditions and children’s needs could be missed. This is evidenced by 96% of health visitors reporting concern about children in homes at risk of domestic violence and abuse during 19 March to 3 June. In addition, the majority of respondents were concerned about parental mental health conditions (92%), child safeguarding (87%), child neglect (81%), the impact of missed needs on the child’s growth (83%) and development (79%), breastfeeding (75%), and their unmet need for support

<sup>2</sup> 60% of respondents reported at least one member of their team redeployed and 41% of these had between 6 and 50 staff redeployed; 10% of those respondents reporting redeployment stated 50% or more of their staff had been redeployed.

to manage the impact of Covid-19 on wider determinants of health (e.g., poverty, social isolation, unemployment). One explanation offered for these concerns is the difficulty of making an assessment of a child's needs digitally, particularly with non-verbal cues being harder to pick up on. The authors strongly recommend that the health visiting service is swiftly reinstated (where this has not already happened) given its "crucial role in the early identification and support of the most disadvantaged families". The need to prevent staff being "overwhelmed by excessive chronic workload and overly bureaucratic processes" is another priority area identified by the study.

Nurses' and midwives' concerns during Covid-19 are being captured by a longitudinal national survey to evaluate the impact of Covid-19 on the UK nursing and midwifery workforce (ICON Research team, 2020).

### **The impact on services and women: the perspective of mental health staff**

A study by Wilson *et al.* (2020) explored the perceptions of mental health care staff on the impact of the pandemic on mental health service delivery and outcomes for women in the perinatal period. The authors carried out a secondary analysis of an online mixed-methods survey which was open to all UK mental health care staff. A total of 363 people who responded to this survey worked with women in the perinatal period, in generic or specialist services. Most (85%) of the 363 staff were female and 70% were White British. In addition, most (91%) were NHS staff, and worked in England (82%). The majority (70%) of respondents worked in a community mental health team (CMHT). Other settings included hospital inpatient services (15%), crisis teams (21%) and community groups (7%).

As part of the survey, respondents were asked which challenges to their perinatal work were 'very relevant' or 'extremely relevant' during the pandemic. Perinatal women's social isolation was rated as most relevant (79% of the sample described it as relevant or extremely relevant), followed by domestic violence and abuse (53.3% of the sample described it as relevant or extremely relevant). Women's mental health was seen as particularly at risk from these stressors.

With regards to staff's capability to support women, respondents stated that they felt less able to assess women, particularly their relationship with their baby (43.3%), and to mobilise safeguarding procedures (29%). These themes mirror the concerns expressed by health visitors in the section above. The report recommended tailoring service delivery to the needs of women and argued that digital appointments are inappropriate for assessments, but could be used for follow-up interaction with perinatal women. Risk assessment and safeguarding procedures need to be robust regardless of the necessary adaptations to how the service operates during the Covid-19 pandemic.

### **The impact on the voluntary sector**

A recent study by King and colleagues (2020) on the impact of Covid-19 on the voluntary sector surveyed respondents from 697 organisations from 21 September-5 October 2020. It should be noted that this survey was answered by a wide range of voluntary organisations, rather than exclusively those involved or linked with perinatal mental health and maternal mental health. 13 of the services were categorised as 'health, hospital, nursing home' (including mental health) and 5% were social services, and it is likely that responses within these categories were those most relevant to perinatal and maternal mental health. Nonetheless, the survey results do give a sense of the overall pressure on the voluntary sector posed by the Covid-19 pandemic.

The survey answers were based on their experience in the previous month. There was a significant impact from Covid-19 on the finances of voluntary organisations, with 4 in 10 voluntary organisations (39%) reporting that their financial position had deteriorated in the previous month. In addition, over a third (34%) of voluntary organisations expected their financial position to deteriorate over the next month. Extra pressures put on voluntary organisations by Covid-19 included increased demand for their services. Over half (56%) of respondents expected demand for their services to increase over the next month. The need to change workplaces and community

venues to make them Covid-secure for employees, volunteers and service users added to existing costs. This is demonstrated by 3 in 5 organisations (60%) reporting that their operations costs increased due to updated hygiene and safety measures, including PPE and needing to accommodate social distancing. The negative impact of Covid-19 on the voluntary sector was seen to be long-term, with 80% of organisations expecting it to negatively impact their work for the next year.

## Limitations of the data in this literature review

The vast majority of findings are based on self-report survey data. This method has been used most commonly during the restrictions of social distancing and lockdown. The data would benefit from being triangulated with data from qualitative interviews and focus groups; however, most studies used surveys. It is also possible that the data may be skewed, as women who were able to complete surveys during this time may have been coping better than other women whose voices are not included here, for whom completing a survey may have been too demanding or too low a priority.

It should be noted that most of the survey data is from earlier on in the pandemic, from March 2020 through to the summer months, and responses tend to be concentrated from England and White British women. There is a need for more research exploring the experiences of women of colour and young mums.

Some studies could not be included as data collection is ongoing. For example, nurses' and midwives' concerns during Covid-19 are being captured by a longitudinal national survey to evaluate the impact of Covid-19 on the UK nursing and midwifery workforce (ICON Research team, 2020).

## Literature review: summary

As background to this review, it is important to note that the Covid-19 pandemic has been found to disproportionately affect women, who are more vulnerable than men to socioeconomic inequalities, gender inequalities, domestic violence and economic insecurity (Robertson

*et al.*, 2020; WHO, 2020a). A range of surveys of women and professionals in the UK have indicated the negative impact of Covid-19 on maternal mental health, including increased anxiety. The reasons for this are multi-faceted and include fear of catching the virus itself, reduced employment, financial problems, and being unable to access support from families, friends and birthing partners due to social distancing. Changes to birth plans, and reduced and disrupted access to maternity services and mental health support, have also caused stress and worry. There is evidence to show that the mental health of women of colour has been affected the most (Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, 2020). Some women encountered cumulative social and economic stresses during the pandemic, including poverty, racism, stigma and interpersonal violence (Howard and Khalifeh, 2020).

Services have been put under increased pressure with a number of staff diverted away from their usual service, leading to increased caseloads for staff remaining in the service, working in a new way. Covid-19 disruption has affected services through fewer face-to-face appointments, less continuity of care, restrictions for birthing partners and changes to birth plans. There have also been difficulties for women in accessing clear information about changes to services. These changes have understandably heightened anxiety for pregnant women and those with newborns. There is evidence of health visitors and mental health care staff being concerned about women's social isolation, their own ability to effectively manage safeguarding risks with fewer or no face-to-face interactions, and staff feeling burnt out. There have been some benefits in digital appointments for some mothers (e.g., they are seen as convenient as there is no travel time needed). Yet it is important to note that many women are not aware of digital support, or unable to access it due to lacking Wi-Fi or technological skills. There is also evidence of the voluntary sector being under greater strain and facing financial pressures from increased demand for services and the need to create Covid-19 safe environments.

## 4. Survey: The impact of Covid-19 on maternal mental health services in the voluntary and community sector

### Who responded to the survey?

The Maternal Mental Health Alliance and Centre for Mental Health circulated the survey link to voluntary and community sector (VCS) organisations in their networks. Organisations were asked to designate one person to respond on their behalf. To maintain anonymity, we did not ask respondents to state their organisation so we cannot conclusively rule out the possibility of double counting (i.e., more than one response per organisation). However, after carrying out checks using three items of data that discriminated between responses, we have a high degree of confidence that a majority, if not all, represent separate organisations.

The survey received 43 responses with a completion rate of 70%. The respondents' organisations operated in one or more of the four UK nations; and those who provided their organisation's annual income were split quite evenly between micro-, small- and medium-sized organisations. The respondents' organisations provided a wide range of emotional and educational services to mothers, partners, infants, children and professionals. Many also provided support specifically for minority groups and for parents with additional needs or vulnerabilities.

The following are themes that emerged from the findings.

### Demand for services

#### The impact of the pandemic on pregnant women, mothers, children and families

The pandemic has created new risk factors and exacerbated existing ones. Many organisations are supporting women with issues resulting from the Covid-19 restrictions, such as anxiety and depression linked to social isolation, and trauma caused by giving birth alone.

*“Also, Covid itself has added to expectant & new parents’ anxiety levels massively and*

*so we believe we are seeing parents we may not have prior to Covid, as the restrictions & isolation of the pandemic itself has been the reason they’re asking for support.”*

Respondents noted that vulnerable women, such as those with pre-existing mental health difficulties, those experiencing financial hardship, and those experiencing domestic abuse have been disproportionately negatively affected by the pandemic.

#### Shortfalls in statutory services

Respondents reported that now more than ever their organisations are filling gaps in statutory services. There have been fewer statutory services available, owing to the redeployment of health visitors and the disruption to routine check-ups with GPs and midwives. The pandemic has also led some women and families to have more negative experiences with statutory care (e.g. giving birth without a partner present), which have affected their willingness to seek help from the NHS. As a result of both these factors, more have sought support from VCS services.

*“[We are] more in demand than ever as health professionals are also under so much pressure, they are even more likely to refer more families on to our services.”*

*“We’ve found so many services have been ineffectual during this time, there has been a mistrust with services directly related to the NHS and we are often having to work with parents who would normally fall under their remit.”*

#### Increasing numbers of people seeking support

A large majority of respondents (88%) reported that their organisation had seen an increase in the level of demand for their services (see Figure 1 overleaf). However, only 46% of organisations have been able to increase their

service provision. The capacity of most has either remained about the same or decreased. It is likely that this is linked to the lengthening of waiting times for services, with 41% of respondents saying that these have increased at their organisation.

### Increasing levels of need among people seeking support

Almost all respondents (98%) reported increasing levels of need among their service users (see Figure 2 overleaf).

### Ongoing high demand

Respondents anticipate that the effects of the pandemic are likely to continue to be felt for a long time, resulting in ongoing high demand for services.

## Staff wellbeing and service capacity

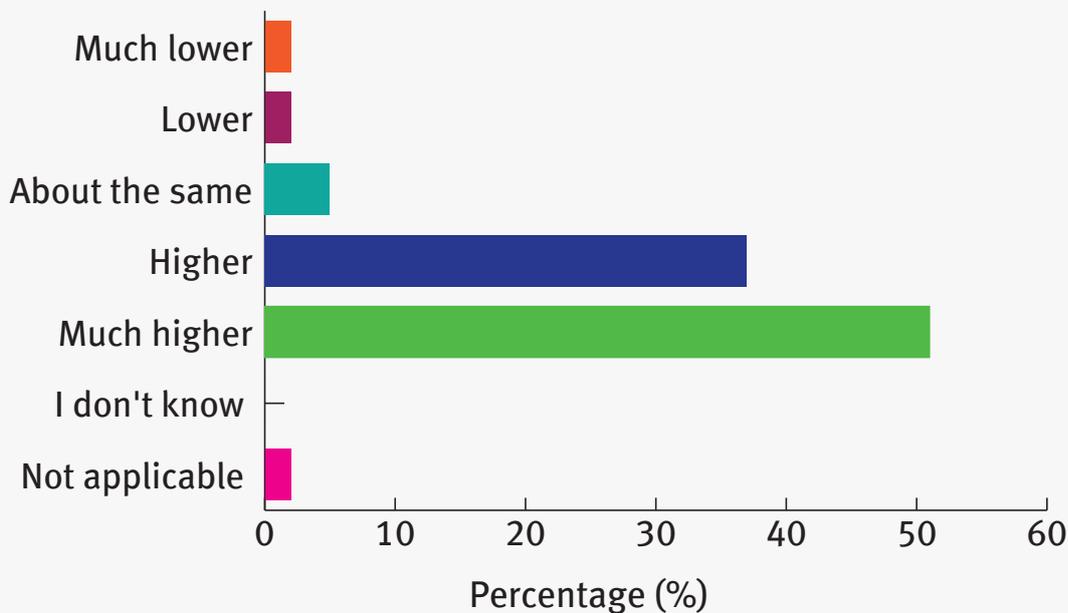
### Decreased staff capacity

Although just over half of respondents (51%) reported that their organisation had not had to furlough any staff, they have seen a fall in staff capacity. Reasons for this include ill health, bereavement and, during school and childcare closures, the need for staff to look after their own children at home.

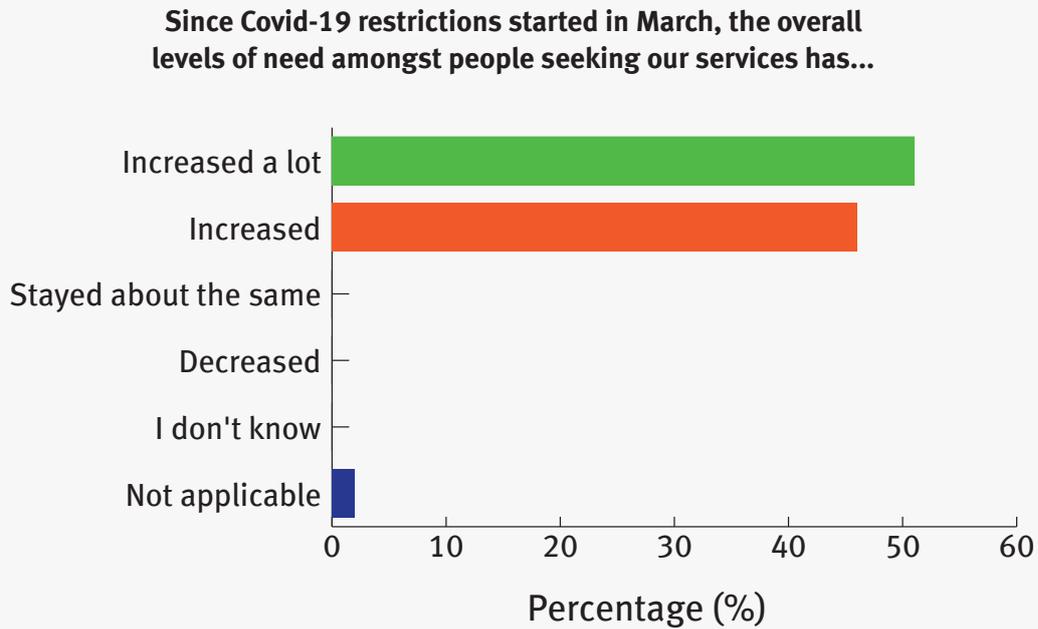
*“Our workforce has been affected, staff or trainers have had bereavement, ill health both physically and psychologically. Now they are home educators for their own children which has an impact on their workload and commitment.”*

**Figure 1: Level of demand since Covid-19 restrictions**

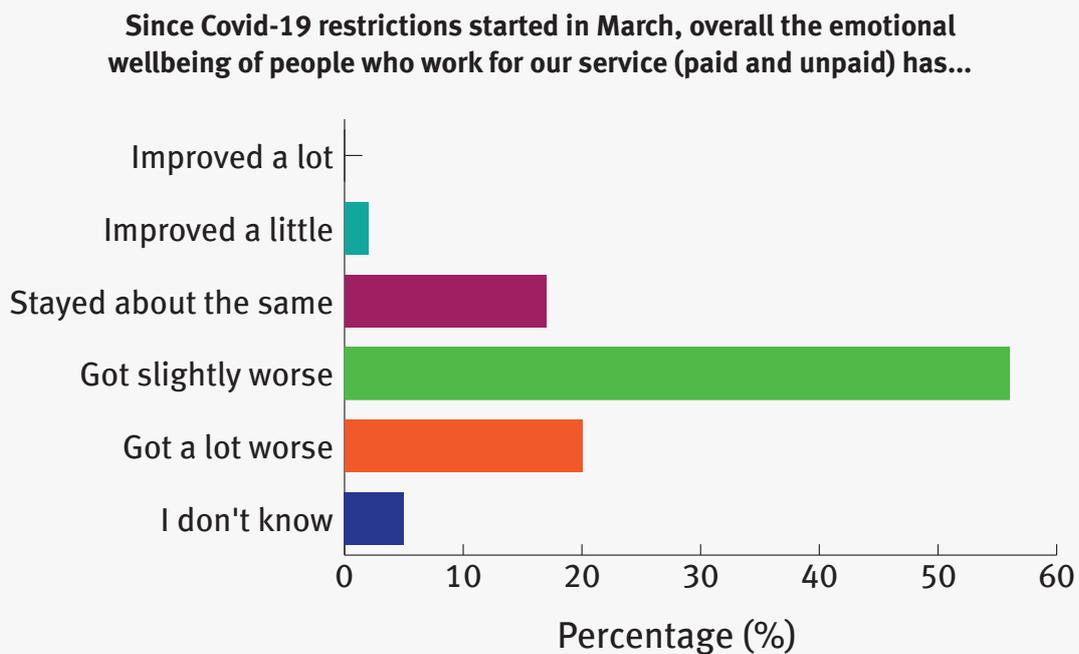
Since Covid-19 restrictions started in March, the level of demand for our service has been...



**Figure 2: Level of need since the introduction of Covid-19 restrictions**



**Figure 3: Changes in staff wellbeing following the introduction of Covid-19 restrictions**



## Increased pressure on staff

Many respondents reported that since the Covid-19 restrictions started, the emotional wellbeing of staff at their organisation has got slightly or significantly worse (see Figure 3). As described above, staff are coping with illness, loss and additional pressures in their home lives. They are also experiencing more demands at work such as larger and more complex caseloads, and the challenge of adapting to new ways of working.

## Digital services

### Moving to online platforms

One of the biggest changes in terms of how organisations are operating is the transition from providing in-person services to providing them remotely. A majority of respondents said that their organisation's communication with service users by phone and video calls has increased significantly.

### Practical challenges

There have been practical challenges to adopting these ways of working, such as investing in, and learning how to use, new technology. For some organisations, it has also created training needs around, for example, online risk assessment, safeguarding and data handling.

### The digital divide

Respondents also expressed concern about the 'digital divide'. Some of their service users, especially those who are facing the most challenging situations, have less access to, and/or are less able to engage with, online support. This can be because they do not have the necessary technology, they do not have a space where they can talk without distractions and without being overheard, or they simply don't feel comfortable with interacting online. Some organisations have sought to address this by, for example, buying internet packages for their service users and providing sessions to familiarise them with the digital platforms.

## Innovation and new opportunities

However, despite these challenges, some organisations were already looking at incorporating these technologies into their work and the pandemic has accelerated this, often with positive results. One organisation noted that, since they became more active on social media, they have engaged with more young parents. Other organisations said that they have been able to reach a larger geographical area and more isolated rural areas.

*"We have created some interesting new ways of delivering services online and by phone which we will continue to develop & use in the future."*

## Face-to-face services

### The importance of face-to-face services

When it came to the challenges of providing services during the pandemic, not being able to meet people face-to-face emerged as the strongest theme. Respondents said that, while phone and video calls are better than nothing (and, as noted above, even have some advantages), they are not an adequate replacement. Respondents doubted their ability to provide the same quality of support remotely, also expressing concern about their ability to carry out risk assessments to a high enough standard.

*"Still unable to transition fully back to face-to-face which is what parents are craving & needing to support their mental health. Our peer supporters too are desperate for that face-to-face contact."*

### Outreach work

One aspect of their work that has been especially challenging with the change to digital platforms is outreach. Respondents noted that it has been harder to identify and reach out to families in need of support.

*“Due to Covid restrictions the Health visiting service has had to significantly reduce the amount of time we're spending liaising with families in their homes and community clinics have completely stopped. Which has been a reduction in the number of opportunities for spontaneous interactions and support.”*

## Financial uncertainty

### The current situation

We asked respondents whether they expected a change in their organisation's income between the end of the last financial year (2020) and the next financial year (2021). 11 did not know. Of the remaining 31 respondents, 21% expected it to be lower; the others expected it to either remain the same (21%) or to be higher (31%). One of the key factors leading to an increase in annual income has been short-term Covid grants.

### Fears for the future

Many respondents were concerned about the availability of funding after the short-term emergency grants have ended. There is some hope that the invaluable role VCS services have played in supporting statutory services during the pandemic will be recognised with greater investment. But, overall, respondents anticipate there will be fewer funding opportunities, owing to the impact Covid has had on the economy. They fear this will affect their ability to plan for the long-term and, in the worst cases, will jeopardise the survival of their organisation.

## Summary

For mothers, partners and children, the pandemic has exacerbated existing difficulties and created new ones. It has also affected the level of support they receive from statutory services. This has resulted in many VCS organisations seeing a rise in demand for their services and also a rise in the level of need among people accessing their services.

This has put pressure on staff at a time when many are also having to cope with challenges in their home lives (e.g., illness, bereavement and lack of childcare), and this has been detrimental to staff wellbeing.

There have been significant changes to how services are providing support. Many organisations have made a rapid transition to new technologies, such as video conferencing and social media.

While these changes have created new opportunities for engaging with service users, they also have shortcomings. A strong theme in the data was the importance of face-to-face support. Many respondents felt that online and telephone services have not been adequate substitutes for in-person services.

Financially, some organisations are currently benefitting from short-term Covid grants. However, respondents expressed concern about their funding prospects in the long term.

## 5. Consultation exercise: findings from evidence-giving events, one to one interviews and written evidence submissions

### Method

We undertook three consultation events and two face-to-face interviews with professionals, from both the statutory and third sector, working in the field of perinatal health, and also received written submissions of evidence.

This section reports our contributors' experiences and perspectives; they may in some cases be reporting an issue that was very localised and not necessarily a universal experience. However, the evidence given to the review was quite consistent and the findings presented, albeit qualitative, were commonly reported from across the four nations.

### How were care pathways affected?

#### Statutory services

The demands placed on the NHS by Covid-19 cases led to redeployment of key perinatal staff (including health visitors and midwives specialising in perinatal mental health or bereavement support).

The NHS Community Prioritisation Plan (March 2020) categorised health visiting as a "partial-stop" service, with guidance to deliver only two of the five mandated contacts and, following risk stratification, to limit face-to-face contacts to those with a "compelling need". As a result, most babies were not seen, or the parent(s) contacted, after the new birth visit. Health visiting to vulnerable babies continued face-to-face but was restricted to one parent. Health visitors and parents are required to wear masks and other PPE during visits.

Less qualified workers were redeployed to cover the health visitor role, for example to undertake the 6-8 week mental health assessment. The Institute of Health Visiting suggests that this crucial check should be done only by trained specialists. Training in matters such as perinatal mental health or bereavement support for other staff was also paused in some NHS providers. The use of less experienced staff in assessing what can be quite a complex issue is a cause for concern.

The Institute for Health Visiting reports significant variation in health visitor redeployment practice, with up to 70% of health visitors being redeployed in some areas. At least one third sector provider reported that redeployment of the perinatal mental health workforce was particularly acute in Wales and Scotland.

In August, services were directed to "fully restore" (NHSE/I, 2020); however, this is locally determined and has not occurred everywhere.

In its submission, the Institute of Health Visiting highlighted that, prior to the pandemic, the average health visitor's caseload was already twice the Institute's recommended maximum of 250. During the pandemic, due to health visitors being redeployed, caseloads have increased further. One health visitor apparently reported a caseload of 2,400 to the Institute. The health visiting service in England entered the pandemic in an already depleted state, with an average 30% loss of health visitors since 2015, significant cuts to the public health grant (Local Government Association, 2019) and widespread variation in quality (Morton, 2020). In some areas the service has been cut by over 50%, creating significant variations in the ratio of mothers to health visitors.

As well as reductions in routine home visits, redeployment of staff, reductions in service commitments, staff absences and the need for infection control, the response to the pandemic has also led to outpatient appointments being reduced and appointments moving to telephone or video conferencing. Continuity of care has also been affected, with mothers seeing different professionals for each appointment. Many appointments with health professionals were cancelled during the initial lockdown period and have continued to be disrupted, with face-to-face appointments with GPs, midwives, health visitors and mental health support professionals replaced by telephone or video calls.

Research by the Royal College of Obstetricians and Gynaecologists found that 85% of NHS trusts and units reported a significant change in ways of working, with 89% of these having reduced face-to-face interactions stating they were unable to offer timely clinic appointments (Royal College of Gynaecologists, 2020a) .

Staff absence has been higher due to requirements to self-isolate, the need for some people to shield, staff contracting the virus and pressure on the workforce (see Impact on the workforce, below). Absences are increasing as testing increases, leading to more cases being picked up and more staff having to isolate.

In addition, some mothers were reluctant to attend hospitals or GPs or to have a health worker come to their home, for fear of infection.

Capacity issues upstream and downstream from perinatal and mental health services impact on the services themselves. One perinatal mental health practitioner reported that their clients were struggling to get GP appointments and prescriptions, while another reported keeping people on their caseload for longer than usual because transition pathways (for example, IAPT or third sector) lacked capacity. Providers reported that specialist perinatal mental health services were putting women “on hold” without active treatment. We were told several stories about service users, including those with severe mental health issues, not getting the help and support they were statutorily entitled to, as a result of capacity issues.

One participant told us that her daughter-in-law gave birth in February. The baby has food allergies and there have been difficulties with sleep and feeding, and blood in his stools. At eight months old, he had not been weaned and wasn't gaining weight or moving the way he should be. He wasn't seen by health visiting at all, even after being admitted to hospital in an emergency on two occasions. In addition, the mother is losing weight and her mental health is deteriorating.

Some mothers have been reluctant to ask for help, not wanting to bother professionals they perceive as already overloaded. The Government's “stay at home” message compounded this, with some mothers interpreting it as indicating that their needs were less important than others. This included some mothers feeling uncomfortable about attending a Mother and Baby unit.

Restrictions to services included (and often still include) women having to attend appointments alone. Following national hospital visiting guidance, some NHS trusts restricted birth partners' attendance during early labour, as well as at antenatal hospital appointments and scans.

Statutory sector service providers moved as many services as possible (both one-to-one and group) to video conferencing, video calls, phone or even text and email. These included health visitors running postnatal groups for mothers with mild to moderate depression and professionals running support groups for colleagues.

During the early days of the pandemic, when most of the necessary protective measures were not in place, midwifery services moved online. There was concern over staff catching and passing on the virus, and a need to protect women and midwives.

As stated elsewhere, women's birth choices have been different and much more restricted. Their partners have not been allowed to attend antenatal clinics. Some home births have been cancelled due to midwife shortages and, once PPE was in place, partners were only allowed to be present during the birth and not during early labour. Midwives have borne the brunt of any anger over this which has made things more difficult for them. Midwives have found it difficult to balance the needs and wants of women and their partners with the risk of spreading infection.

## Voluntary and community sector (VCS) support

Likewise, it was clear from submissions that VCS providers acted quickly to adapt services, moving groups, peer support sessions, peer mentoring, counselling sessions and other services to video, phone, closed social media groups etc.

Many sought to address gaps in provision and head off emerging crises through additional services, including the provision of food parcels, activity packs, “care packs” containing small luxuries and treats, maternity clothes, nappies and other essential supplies. Some providers accessed urgent assistance funds to enable women to buy things that they might otherwise have bought cheaply second-hand, for example from charity shops.

Naturally, it was no longer possible to provide crèche support to activities.

We heard suggestions that some groups may have closed permanently as a result of the situation, although this was not the case for any of the organisations who took part in the research.

## Informal support

As well as experiencing statutory and VCS service reductions and adaptations, mothers have experienced barriers to creating and accessing informal support networks, including from family and friends.

Restrictions on group activities, most of which have either moved online or ceased at least temporarily, have reduced mothers’ opportunities and ability to interact with other families and make friends.

During the initial lockdown, mothers were unable to meet with family and friends who were not part of their household. Even when restrictions have been eased, meeting others has been subject to regulations. Mothers living in areas where people aren’t permitted to visit them are subject to the vagaries of the weather and not all of them can afford to meet people in cafés, even when cafés are permitted to trade. Garden visits may be permitted, but not all families have gardens.

## What is the impact on families?

### Worsening perinatal mental health

Perinatal mental health is affected in complex, interrelated ways by the pandemic and the associated restrictions. The pandemic, in itself, is an additional source of anxiety on top of the reductions, adaptations, and restrictions on services it has led to. These restrictions mean that women are neither getting the support that would prevent normal anxieties worsening to the point of needing clinical help, nor receiving appropriate or sufficient support with existing mental health issues.

This applies to statutory services, third sector support and informal support from family and friends. Perinatal women are isolated and having to cope alone. Many mothers feel abandoned, with heightened anxiety and impaired ability to enjoy all aspects of pregnancy, birth and motherhood.

Parents have not had the usual range of maternity, birth and perinatal choices and, despite the best efforts of health care professionals, many women have not been able to have their baby in the way they would have chosen under normal circumstances. Many mothers feel they have been robbed of the pregnancy, birth and early parenting experience they should have had. Their birthing plan had to be abandoned and they feel the whole experience of being pregnant and having a baby has been stolen from them. Some feel that both they and their child have missed out, saying things like, “This wasn’t supposed to be the story when I had my baby”. They have been unable to do the normal things mums do with their baby.

Our contributors reported that some women felt that had “lost” this year and will never get that time back with their baby. Providers told us that some mothers are describing themselves as “grieving” because they’re getting ready to go back to work without having had the experiences they planned for their maternity leave, like attending baby groups, and taking opportunities to introduce their baby.

Our contributors told us that disruptions and uncertainty around care pathways, and the requirement to attend appointments alone, have heightened parents' anxiety and the pressures on them, leading to more parents experiencing perinatal mental health problems. As indicated in other sections of this report, the VCS is reporting a huge rise in demand for their services and for perinatal mental health support. Families are experiencing more complex, nuanced, and intense issues, existing mental health issues are worsening, and providers reported an increase in suicide attempts.

The evidence we were provided in the consultation indicated that due to the reductions and restrictions to services, women who experience perinatal problems were getting help later and often didn't get the type of support they needed. For example, health care workers have been finding it more difficult to spot breastfeeding problems at an early stage; having to interact through video instead of the intimacy of a home visit, which helps develop a trusting relationship with a midwife or health visitor, women may feel less comfortable disclosing breastfeeding difficulties. Even when difficulties are identified or disclosed, digital support for a mother who's struggling with breastfeeding cannot fully replace sitting beside her.

This extends to identifying emerging mental health issues, which can lead to women reaching crisis, perhaps making a suicide attempt or having their children taken away, before they access support. Even at this point, it can be difficult for them to access statutory services. One third sector provider reported being unable to secure specialist perinatal mental health support even for women who were suicidal.

We were told that some women hide the fact that they have mental health problems, because of fear and stigma from those around them. For this reason, some midwives have tried to prioritise face-to-face contact with those they know have previously had mental health problems.

Evidence from a survey conducted by Action on Postpartum Psychosis on over 70 women (the majority of whom had a history of severe mental illness) found that for approximately 75% of respondents, Covid-19 had a negative impact on their mental health and for nearly 40%, this had been markedly so.

### Increased anxiety

Our contributors reported that mothers have been anxious about issues including:

- Not knowing what prenatal and postnatal services were available.
- Not knowing where it was safe to give birth.
- Uncertainty about, and the reality of, restrictions on partners' involvement, including partners not being able to attend scans, and limits on partners attending full labour and visiting after the birth. Accurate information about statutory service adaptations wasn't always effectively conveyed, leaving some mothers unnecessarily anxious that their partners wouldn't be able to attend appointments or labour with them.
- The risk of complications during birth that would lead to an extended stay in hospital, which in turn would lead to the other parent missing out on bonding with their baby in the early days and both parents feeling isolated.
- How they would cope with a new baby without the support of extended family, friends and a structure of activities to attend.
- Being penalised for breaking lockdown restrictions (whether knowingly or not) to obtain childcare or support. Some mothers in acute need are reluctant to do what they need to do for fear of breaking the rules. One practitioner reported that even issuing mums with clinical letters to say they are allowed to have visitors in their home didn't allay their anxieties enough for them to do so.
- Having to isolate and therefore not being able to have contact with others who could provide support.

- The impact of social isolation on their baby’s social development.
- The possible impact of Covid-19 on their health and that of their child (both pre- and post-birth). Pregnant women being identified as a group at higher risk of developing severe Covid-19 was a source of anxiety for mothers: the fear of contracting Covid-19 and, in the earlier stages of the pandemic (before the age profile of Covid-19 infection and implications were known), the fear of their baby catching it. When restrictions were lifted and nurseries reopened, many women, despite desperately needing time away from their toddlers, were concerned that they were putting them at risk of infection.

However, as more has been learned about the age profile of Covid-19 risk, this anxiety has eased. Going into the second lockdown, our contributors reported mothers were delighted that nurseries and schools weren’t closing (although they were anxious about having to self-isolate if someone in their child’s bubble tested positive).

Some of these anxieties are compounded by each other. For example, providers reported mothers worrying about their baby’s lack of social interaction during lockdown and then, when restrictions lifted, worrying about other people touching their baby and exposing it to infections. At this time, it is harder than ever for mothers to feel they’re making the right decisions for their baby.

### **Isolation and having to cope alone**

Support from partners, from immediate and extended family, and from friends, is vital in the challenging perinatal period. Social distancing and social isolation rules mean women have had to go through this period without face-to-face contact with their parents, extended family and friends, and it has been harder than usual to make new friends with other new parents.

Restrictions on partners attending antenatal and postnatal appointments (including scans), being present for early labour or induction of

labour, and visiting postnatally, has therefore been upsetting and challenging. Further, while some partners have been at home more than they normally would, others have been working longer hours for fear of job insecurity or to build up funds in case of redundancy.

Having to attend appointments alone is particularly hard when complications are identified. Mothers have had to process the information and potential consequences on their own. Partners have been excluded from decision-making. Some women have given birth alone, or found out they have miscarried or that there are complications with their baby, without the support of their partner. We were told of one case where a mother was asked to make a decision as to whether to terminate a pregnancy, and had her request for her partner to join her declined.

Not being able to attend clinics or mother and baby groups has prevented mothers from making friends with other parents and creating a support network which, in normal times, is hugely important. Friendships formed at such groups can last a lifetime and women who have given birth during the pandemic are aware of having missed out.

Where support groups have moved online, providers report that it has been challenging to replicate the opportunity for mothers to swap contact details and develop relationships. Opportunities to make connections are not the same. Normally mothers would be able to go to each other’s houses, sharing their experiences of sleep deprivation and comparing notes to help them understand what’s normal and what’s not.

As a result, parents are missing out on the “normalisation”, or containment of the natural worries that come with being a new parent, that they would usually get from meeting with other families. Isolation compounds anxiety that might be alleviated through an informal conversation - “Is this normal?” - with a friend or relative, or an aside to a health care worker or third sector support worker.

During the pandemic, when mothers have had a bad day and “think they haven’t done anything right and they’re the world’s worst mother”, they have had no one outside those they live with (if anyone) by their side to “mirror back”. Participants explained how, under normal circumstances, a professional would be by their side saying something like, “Look at the smile your baby just gave you. That’s lovely” to help parents grow in confidence about their parenting.

Because mothers are not being supported around their normal anxieties, such anxieties are reportedly being magnified and some reaching a clinical level. Further, those giving evidence expressed that anxiety itself is becoming normalised: anxious mums don’t like to ask for support, or feel guilty about doing so, because “everyone’s anxious”.

Another knock-on effect noticed by some providers was that, without peer support (and with reduced partner support if their partner was working longer hours than usual), a higher number of women were unwilling to attempt breastfeeding.

Not being able to attend clinics or mother and baby groups, or meet friends and family, has prevented mothers from getting respite, such as someone else minding their baby while they make a cup of tea or take a shower. Instead, many have been almost constantly in sole care of, and often in physical contact with, their baby. This can be overwhelming.

Providers stressed that activities such as baby groups (baby sensory, baby massage, playgroups etc) provide important structure to mothers’ time and serve as coping mechanisms for the stresses of new motherhood.

Reduced access to sports and fitness activities has also impacted on mothers, who have struggled to maintain activity to the recommended levels.

Thus, the impact of the temporary cessation of many “non-essential” services and the necessity for others to be delivered remotely has demonstrated that they are, in fact, essential.

Providers reported that specific exempt support groups (for example, baby groups for mothers with poor mental health) being permitted to continue face-to-face has been a lifeline for some families.

As restrictions relaxed, and mothers were expected to go out and about more, some women found coming out of isolation difficult. They weren’t used to other people interacting with their baby, while anxiety about the situation has been compounded by confusion and lack of clarity over frequently changing legal restrictions and guidelines. Who’s allowed into the house? Should a grandparent be allowed to hold the baby? What are we allowed to do? What is it sensible to do? This adds fear of breaking the rules to mothers’ anxieties about their health, their babies’ health and protecting older family members.

As the situation has continued, some of the issues have intensified. Back in March 2020, few people understood how long restrictions would last or what the future held. As a result, professionals were unable to fully prepare women for it. Participants in the consultation told us that it’s been hard for women to keep faith and see light at the end of the tunnel while they isolate from their family and wider support networks. Even mothers who initially enjoyed the way lockdown removed the pressure to go out are, at this stage of the crisis, missing their support network.

### **Increase in traumatic births?**

Health visitors told us there has been an increase in women reporting traumatic birth experiences, often due to their partner not being there or only being present behind a screen.

We were told that midwives had not reported any marked increase in traumatic births, although they had observed some women delaying coming into hospital until they were later on in labour, as they did not want to be alone and without their partner (who could not be present in early labour).

Some women who were very concerned about catching Covid-19 might have opted for a home birth, even without midwife support. This so-

called ‘freebirthing’ was a concern to midwives and they encouraged women to see hospital as the safer place to have their baby.

### **Impact on infant development and mental health**

Participants anticipated that some mothers and children will experience long-term mental health impacts of the issues identified in this report.

There are fears regarding the impact on the social development of babies who might not meet adults other than their parents for the first several months of their lives. Parents are reporting changes in their baby’s behaviour, such as becoming clingier and more introverted, and GPs have observed babies that are alarmed to meet a stranger at the six-week check. Even when face-to-face contact takes place, masks and other PPE create a barrier between the parent and the child, and between staff and babies.

### **Impact on partners and extended families**

It can be hard for partners to achieve the level of engagement they would like, even in normal times. The current situation worsens this, particularly if their partner and baby have an extended stay in hospital.

In the consultation events we were told that partners feel excluded and helpless when they are unable to attend scans, other appointments or the birth, or visit their partner and new baby in hospital. They are left feeling as though they are simply spectators, unable to ask questions or engage with the care pathway and less able to bond with their baby. They may develop poor perinatal mental health themselves, possibly as a result of their partner’s problems, possibly independently. Partners who have been present at a traumatic birth, witnessing the wellbeing of both their partner and their child being seriously compromised, are at risk of developing post-traumatic stress disorder.

Naturally, working with a partner who feels disempowered and frustrated, and may be less emotionally connected to the baby, further impacts on the mother, who may be less well supported in her navigation of the care pathway.

Relationships between mothers and their partners have been under additional pressure due to insecure employment or job loss, reduced incomes, a lack of access to safe outside space, and restrictions on leaving the home or meeting others which have prevented them from having a break from each other and their children.

Since November 2018, in England, the partners of mothers referred to perinatal mental health services have been eligible for a mental health screen. Services for partners have been evolving, with greater recognition of the need for partners to be included in all aspects of maternity and birthing. Providers in England reported that, during the pandemic, this progress has been set back.

With the situation continuing for many months, extended family members may be yet to meet their new relative, impacting on family relationships, and support for the child’s development, perhaps permanently. Reports were that families are saddened by things such as missing out on the opportunity to take photos of extended family members with the new baby.

### **Potential ‘silver linings’**

Our contributors reported that some mothers, and providers, experienced silver linings to the situation. Some families had a “baby moon” for the first month of their child’s life, for example because their partner was furloughed and thus at home more than usual, and because there was no pressure on them to maintain usual standards of home management, to go out of the home, or to entertain a stream of visitors wanting to meet the new baby.

The reduction in pressures and expectations experienced by some women enabled them to concentrate better on breastfeeding. Thus, while some providers reported a reduction in breastfeeding, others reported an increase.

Some mothers benefitted from having a shorter stay in hospital, while some hospital staff reported being able to provide better quality care, due to not being interrupted so much by visitors. In addition, having fewer visitors sometimes led to women on wards interacting more with each other.

While most third sector providers were anticipating a reduction in future funding, several had been able to extend their provision or reach as a result of adapting their services, some with government funding. One reported that, as a result of successfully applying for funding to adapt, its income this year would be the highest it had ever been.

Because providers have been operating online, women have been able to access services beyond their local area.

Some providers had been able to increase interaction with a baby's other parent because they were at home more, perhaps on furlough or working from home.

VCS sector providers report that some women have been disclosing more during one to one buddy phone support sessions, than they did face-to-face.

Some mothers preferred accessing services from home, although there is a perception that many are beginning to tire of it, finding video conferencing draining.

## The impact on need for services

### Change in demand

Both VCS and statutory providers reported increased demand for their services, and many reported that increasingly complex cases were being signposted and referred.

They attributed the increased demand firstly to the additional challenges posed by the pandemic and restrictions (for example, if someone was already mildly anxious, not being able to have their partner at the birth might be enough to make them reach out for help), and second, issues worsening due to not being addressed at an early stage.

However, many providers also reported that referrals to IAPT services and their own services had fallen, though some reported that, while referrals from professionals had reduced, they had been more than replaced by a surge in self-referrals.

### Demand doesn't fully reflect need

Providers were unanimous in believing that any reduction in referrals, rather than reflecting reduced need, were a function of mothers not seeing their GP, midwife or health visitor face-to-face (or seeing them less often), community resources (such as children's centres) being closed, and referring services prioritising those most in need.

Perinatal mental health services report that referrals have been happening later and have therefore been more complex by the time they are addressed. Some providers suggested that referrers had erroneously believed some services to be closed and that this had delayed referrals.

The suggestion that demand was temporarily held back is further borne out by the fact that, in June and July, as health professionals started to return to post, and lockdown restrictions were eased, referrals from professionals increased and providers experienced a surge in demand.

Providers therefore anticipate that a backlog of demand will emerge as the pandemic, and associated restrictions, ease.

### An increase in vulnerable families – and difficulties identifying and supporting them

The pandemic and the associated restrictions have made more children vulnerable as a result of their parents experiencing insecure employment, job loss, reduced incomes, isolation, relationship strain – and poor perinatal mental health.

It's been widely reported that domestic abuse (including violence and coercive control) has increased during the pandemic and this was highlighted by many providers.

Yet providers reported a reduction in safeguarding referrals from health visitors, GPs and midwives (in one case a reduction of 80%), leaving them wondering what was behind this. Was it that questions about mental health were not being asked? Were the mothers not being seen? Some third sector providers also reported that they had also made fewer safeguarding referrals during the pandemic.

Providers were unanimous in feeling that an increase in vulnerable families has been masked by the restrictions making it more difficult to identify such families. Digital appointments, reduced contact with professionals, and increased health visitor caseloads have all made the identification of emerging issues – and vulnerable individuals – more difficult than usual. Assessing risk is harder and women are less likely to disclose. Thus, at a time when a higher proportion of children are becoming vulnerable, some are not being identified. As one health visitor put it, “if you don’t look, you don’t find”.

Providers universally reported that it is harder, by phone or video, to interact with babies, to assess how families are interacting with babies or to carry out the holistic assessment that a home visit makes possible. “You don’t see how she walks into the room. The glimpse of the body language. The glimpse of the interaction with the baby. It’s just not the same”. Wearing masks also reduces non-verbal cues that can help with risk assessments.

This extends from identifying the “regular” kinds of issues that mothers struggle with to spotting safeguarding issues. For example, the professional can’t assess the state of the home beyond the section of it visible through the camera, and it is difficult to ascertain whether a mother is participating from a safe and private space. The professional may be unaware that someone is just off camera directing the mother as to what she can and can’t say. Even if they suspect this, there is no easy way to check: asking the mother to scan the room with her camera might result in her being prevented from engaging in the future.

The challenges are resulting in support not being offered until problems have reached a worse stage than they would have done in normal circumstances.

Restricting face-to-face health visiting of vulnerable babies to one parent meant that only one parent was supported to develop appropriate skills, and parents were less able to support each other. It also risks stigmatising families who receive face-to-face support, if community members notice the health visitor attending.

Despite this context, health visitors have been under pressure to make quick decisions as to whether a family should receive targeted support. The Institute of Health Visiting suggests that making that decision too early is risky. For example, postpartum psychosis isn’t picked up by the Edinburgh Postnatal Depression Scale (EPDS) and can affect mothers from any social background.

Health visitors reconnecting with families when restrictions eased reported that the number of vulnerable children had “skyrocketed”.

### **Groups experiencing particular difficulties**

Those taking part in the consultation reported that the pandemic and associated restrictions have exposed, and worsened, stark inequalities in care and outcomes across the population. Moreover, the less confident mothers are, or the less adept they are at navigating the care system, the less likely they are to get support – and it is these mothers that often need support the most.

Our contributors indicated some groups that experienced particular difficulties at this time and reported the following:

#### ***Women of colour***

Women of colour were reported in one of our submissions from a large national charity as experiencing higher rates of mental health problems and an increased likelihood of experiencing psychosocial risk factors such as poverty. Despite this, fewer than expected receive diagnosis or treatment for perinatal mental illness, facing barriers of language, stigma and a lack of culturally competent specialist provision (Maternity Action, 2018). These disparities have been widened further by the pandemic (Knight *et al.*, 2020).

More research is required to understand the impact of the pandemic on the mental health and wellbeing of women of colour, and their access to care. Through its Race Equality Taskforce, the Royal College of Obstetricians and Gynaecologists is working with partners to understand disparities in care and outcomes for women of colour in more detail.

***Travelling communities***

Travelling communities were reported to have “slipped under the radar” as collaboration between services (such as the police, mental health services and social workers) reduced during the pandemic, impacting services’ ability to ensure children’s safety.

***Refugee and asylum-seeking women***

Women in these groups are often in poor accommodation with little money, and also frequently lack internet access. They may be given a phone but with limited minutes, and one statutory perinatal mental health service reported mothers being unable to contact the service because they’d run out of credit, and cafés where they might have accessed the internet were closed. Such women are often already isolated, and the pandemic has worsened this. Their specific needs, such as particular food requirements, are less likely to be being met at this time.

***Women from South Asian communities***

A VCS provider reported that some members of South Asian communities found it more difficult to work with them digitally on mental health. This may have been due to privacy issues (e.g. using shared devices), or stigma attached to seeking support from outside the family. Doing so may be regarded as criticising the family, who the mother may live with.

***Language barriers***

Without their usual sources of support, people with language barriers (including not having English as their first language or needing sign language support) may not know what services are available or how to access them.

***Single parent families***

Increased isolation and lack of support has led to an increase in single parent families struggling to access services, or even basics such as food. When government guidance stated that only one member of a household should shop for groceries, some single mothers were unsure how they could do their shopping.

***Relationships under strain***

People who were in relationships that were already under strain, and which have come under increased pressure (including where there is an existing history of domestic violence, abuse or coercive control), have experienced particular difficulties. While the situation has increased the frequency and intensity of incidents, being confined to the home has made it more difficult for women to avoid or de-escalate them.

***Working in higher risk settings***

There has been a lack of occupational guidance for pregnant women working in high-risk settings, leading to high levels of anxiety and uncertainty as to whether they should be continuing to work.

***Access to the internet and online technology***

People who lack internet access will have struggled to access any support provided online. The poorest mothers may not have appropriate devices or be able to afford the necessary data or calls. Some are unable to access services from home due to an abusive partner or cultural constraints. WiFi in cafés can be an important resource for this group, so cafés being closed during lockdown acts as another barrier. Some rural areas have poorer internet services.

***Support organisations not operating***

People who were receiving support from organisations that are not operating during the pandemic, such as Children’s Centres and some third sector providers, will also have struggled. One participant reported that voluntary services for women in their area who had experienced female genital mutilation and for women who had children removed, ceased operating during lockdown. This is a major loss for such women.

***Mothers and anxiety***

Mothers who would have been anxious in normal times, including mothers who have lost one or more previous pregnancies, are made more anxious by the restrictions and the fear of infection. Previously bereaved parents who are

pregnant again are unlikely to be satisfied with phone or video consultations. They want to have a face-to-face appointment and the reassurance of hearing their baby's heartbeat.

The increased anxiety has prevented some women accessing services and even, in some cases, trying for a baby at this time, despite having been planning for this.

A group of women that many of our contributors highlighted as suffering particular difficulties and for whom the pandemic and restrictions posed significant risk were those with a history of previous poor mental health. The discussion and evidence on these women from our consultation are discussed in the section below.

### **A history of poor mental health**

Women with poor mental health or a history of mental health problems are at higher risk of developing perinatal mental health issues, including postpartum psychosis and obsessive compulsive disorders (including women who have heightened concerns about contamination, which are more likely to be triggered by the pandemic).

Women with a history of severe postnatal illness have a 50% risk of relapse after the birth of their next baby (Royal College of Psychiatrists, 2018). Their fears about birth, support and the care that will be available to them are even more intense than those of other mothers. Even those whose mental health issues have been under control are concerned that having a newborn (and possibly other children) without sufficient support will trigger a relapse.

Preventing this depends, in part, on providing routine and stability. Instead, routine home visits and outpatient appointments have been disrupted, reduced and replaced with telephone or video services.

At the same time, women with a history of severe postnatal illness have been prevented by the restrictions from using many of their usual strategies, and well thought-through plans to manage their risk of relapse have been undermined. Increased time spent alone caring for babies, and long stretches without support, exacerbate the risk of intrusive thoughts of harm for those women who experience them.

In addition, some women with mental ill-health have experienced disruption to their mental health support and/or medication supply.

During the consultation events it was reported that the ban on partners being present during delivery is particularly difficult for women with a history of mental illness. Their partner may be the only person present who knows them under normal circumstances, as well as knowing early symptoms of relapse, the severity of their mental health history, and the support they need. Thus, knowing (or fearing) they won't have their partner with them during delivery can cause high levels of anxiety and stress.

Many women living with a mental health problem were already isolated before the pandemic. Usually, perinatal mental health services would support them to build a "scaffold" of support, drawing on community and voluntary services as well as statutory services to, as one professional put it, "build the village it takes to raise a child". Without incidental interactions with professionals or other mums, they lack informal advice which might prevent mental health issues building up. The feeling of being trapped with their baby is heightened and cannot be relieved in the usual ways, e.g. by attending a baby sensory group where someone might offer to hold their baby while they go to the toilet or make a cup of tea.

We were told by some of our contributors that women with mental health issues attending multi-disciplinary team meetings via Microsoft Teams may find it difficult to concentrate, especially when joining the call from home (e.g. while on leave from a Mother and Baby Unit), preventing them from getting the most out of the meetings or fully understanding discussions. Technical difficulties can increase stress. These additional stresses may increase the risk of developing another episode of mental ill-health, and certainly increase the trauma and sense of helplessness reported by women.

Those participating in the consultation reported that an absence of home visits by health professionals, and disruption of routes into care (via GPs, mental health crisis teams, Accident and Emergency etc), makes identifying postpartum psychosis at an early stage more

difficult. Often, identification is dependent on women's partners (who may have no knowledge of the condition) noticing that something is wrong. Even when women at risk are identified, some are reluctant to become an inpatient due to fears about contracting Covid-19, restrictions on visiting at Mother and Baby Units, and changes to the way women are cared for to manage infection risk. For example, Ribblesmere Mother and Baby Unit, in Chorley, has accommodation for visitors but access is limited due to the need to deep clean after each use.

As a result, women are often more severely ill by the time they are admitted, impacting on treatment and recovery. This is particularly concerning since research shows that inpatient care in appropriate settings (such as Mother and Baby Units) is the most effective route to recovery from severe perinatal mental illness. Suicide is the leading cause of maternal death, and untreated postpartum psychosis and severe forms of other perinatal mental illnesses tragically increase the risk of suicide. The *Saving Lives, Improving Mothers' Care* rapid report by MBRRACE-UK, covering the initial lockdown period, includes a case study of a woman with postpartum psychosis who took her own life: professionals did not identify the severity of the illness over the phone, dismissing her husband's distress and repeated attempts to get help.

During the pandemic, women must self-isolate before being admitted to a Mother and Baby Unit. Being admitted can be a frightening experience in "normal" circumstances, and isolation, especially whilst experiencing severe distress, including hallucinations and paranoia for instance, makes this even more difficult. The requirement to self-isolate also makes going on leave from a Mother and Baby Unit more challenging than usual, leading to some women going on leave for extended periods before they are ready to do so, and others remaining longer than needed on the unit.

### Support and isolation

Support from immediate and extended family, and from friends, is vital during recovery from severe forms of perinatal mental illness, such as severe postnatal depression and postpartum

psychosis. However, social distancing and social isolation means women are having to go through recovery without these networks, making recovery even more of a struggle than under normal circumstances.

We were told that women who have been shielding have been particularly isolated.

We were also told that during the pandemic, some women who do not have primary custody of their child(ren) are being denied access and are having to apply to the courts to have access enforced, with obvious costs as well as mental health implications. One circumstance in which some women lose custody of their child(ren) is as a result of developing postpartum psychosis and a lack of Mother and Baby Unit provision. Their partner might take temporary primary custody and the relationship between the parents might break down. Sometimes the court then rules against the child being removed back to the recovered mother on the basis that the father is providing adequate care.

Participants in the consultation reported cases of women who had experienced sexual abuse not being permitted to have their partner with them at scans and suggested that exceptions should have been made in these cases.

Our contributors stated that families in unsuitable accommodation are likely to be facing particular difficulties. A VCS provider reported that their perinatal mental health team assesses accommodation as a social problem, rather than a perinatal mental health issue, although accommodation has a big impact on mental health. They gave an example of a woman, who already had a toddler, being discharged six hours after a caesarean to her one-room accommodation, with a bathroom and kitchenette shared with strangers.

Even families whose accommodation would not normally be assessed as inadequate may have lacked space during the pandemic, particularly if they had other children that had to be at home during the first lockdown, and possibly had to home-school.

Many families were facing financial difficulty and food poverty prior to the pandemic and these, with unemployment, have intensified

as a result of the pandemic and associated restrictions. Businesses have closed, employment insecurity has worsened, and incomes have been reduced. Delays in being able to register a birth have affected some benefits claims. At the same time, the closure of childcare provision and schools has required parents to provide more food for their children. Providers at our consultation events report an increase in families needing recourse to food banks.

Those at our events who support parents after a traumatic birth reported that levels of trauma, for both partners, were deeper and greater: for the mother because she had to cope alone; for the partner, as a result of being excluded from the birth. Counselling services reported that it's more difficult to process trauma online, without a physical connection. At the same time, parents have been less able to access peer support services, which are usually helpful in this situation. Providers were concerned that this would lead to longer-term post-traumatic stress disorder and other mental health issues.

Women and families who have suffered a miscarriage, stillbirth or neonatal death have often been unable to access face-to-face support. Memorials for lost loved ones are being postponed, and reviews and investigations following a stillbirth or neonatal death are being delayed. The death of a baby is a devastating loss and, with the added confusion and upset due to Covid-19, the impact upon families' mental wellbeing during this time could be substantial. Providers reported that recent improvements to the care pathway for bereaved parents, such as standardised appointments to review outcomes and consider future pregnancies, and rainbow clinics, have "fallen away". Bereaved parents are having to "fight, push and repeatedly ask" for support.

Providers at our events told us that bereaved parents sometimes felt they didn't have the right to grieve because there are bigger things going on, and their family and friends didn't want to hear it. This can lead to grief turning into shame.

Families in geographical areas that already lacked provision, particularly if they lack private transport, are likely to have faced particular difficulties. For example, there is as yet no Mother and Baby Unit in Wales or Northern Ireland and some providers reported that, even in nations with Mother and Baby units, families had to travel up to 2.5 hours to reach one. A North East England organisation reported that the site for a planned Mother and Baby Unit in their area had been requisitioned as a Covid-19 ward, and the development of the unit put on hold. At the time of writing, Northern Ireland has only one specialist perinatal mental health service, and levels of service remain particularly patchy in Scotland and Wales.

Families in rural areas that lack transport are even more isolated than usual. For example, some bus services have been further reduced due to lack of demand. Transport issues compound the challenges of partners visiting patients in Mother and Baby Units.

Our contributors told us that parents without existing networks of family and friends lack sources of support. This includes parents with experience of being in care during their childhood, particularly if they are in a relationship with someone else who was in care, and parents whose families live abroad. Some partners were also trapped abroad by the pandemic in the immediate period following the birth.

Those with babies with disabilities or other health challenges were reported to be struggling to access sufficient support.

Families with children registered with Child Protection Services and/or in Family Proceedings are having to attend meetings and conferences digitally, and we were told that some families are disengaging as a result.

First time mothers are more likely to feel uncertain and unsure about whether what they and their baby are experiencing is "normal", and this is exacerbated by the restrictions. They may not know where to seek support or even that they need support, and the reductions in midwifery and health visiting meant many didn't get signposted.

Some qualitative data, shared with the review, from the LGBT Mummies Tribe sheds light on the impact of lockdown on LGBT maternal mental health. High anxiety was experienced by birth mothers and partners in the situation of receiving information on miscarriage and still birth, without their partner being able to be present. The inability to attend transfers, retrievals, scans or other appointments with one's partner due to restrictions caused increased isolation and anxiety for the birth parent. Not being able to have a birthing partner or Doula at birth caused higher levels of stress and anxiety. Some felt that staff in maternity and perinatal services are too busy, and can therefore at times lack empathy or compassion to people calling for reassurance or advice.

With regards to the experiences of non-biological mothers or parents, there were anecdotal reports of a deterioration in their mental health from not being able to attend any milestone appointments for the baby or the pregnancy, instead having to remain outside the hospital in the car park, unable to share good news or feel involved. Anecdotal evidence showed that some biological and non-biological partners felt detached from one other due to the inability to share important moments through the journey with each other. Some non-biological parents really struggled at this time with their mental health. This was associated with their feeling of being an “outsider” – not involved in the whole process of making the baby, appointments, scans nor the birth – which could lead to reports of difficulties in bonding with the baby.

### **A postcode lottery**

The *Babies in Lockdown* report (Best Beginnings *et al.*, 2020) highlighted wide geographical variations in access to care, information and support plus differences between the experiences of specific communities. People from already disadvantaged backgrounds are feeling the impacts of the pandemic more

acutely, including in areas such as care at birth, breastfeeding support, weaning support, access to information, and concerns about mental health.

Services across the country are inconsistent and this has worsened during the pandemic. For example, whether or not partners were permitted to attend scans, other antenatal appointments and the (entirety of) the birth varied between NHS providers, leading participants to question the evidence base for such decisions. One participant cited the example of a mother who wasn't permitted to have her partner with her as their baby underwent 12-hour surgery.

While the vast majority of health visiting services ceased face-to-face visits, at least one continued. Although official guidance now states that health visiting can be undertaken face-to-face, we were told that not all services had resumed at the time of our evidence giving events (October/November 2020). Likewise, whether perinatal teams will do home visits or not varies. Hospitals, even within the same trust, sometimes have different policies around, for example, whether partners can be present during scans and early labour.

According to data collected for 144 NHS trusts in England, Scotland and Wales by an independent doula, analysed by The Guardian in September (2020), half of the trusts and health boards covered by the research were still restricting partners from attending at least two of three key moments (the 12-week scan, the 20-week scan and the duration of labour) during the easing of restrictions over the summer. The research showed that, despite guidance issued in August by NHS England (BBC, 2020), the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, 43% of NHS trusts had not eased restrictions on partners attending antenatal appointments, being present throughout labour, and staying with new mothers and babies after the birth.

## What is the impact on the workforce?

Safe staffing levels and protecting the workforce from stress are conducive to better patient care and experiences. At this time, the perinatal workforce continues to be under severe strain. Statutory and third sector workers have “gone above and beyond” to keep mothers and children safe and well. This has in many cases, and often for months on end, included working long hours and adapting to rapidly changing situations and new ways of working, often with inadequate IT equipment or PPE. Research by the Royal College of Obstetricians and Gynaecologists found that more than a quarter of NHS trusts/units reported workers doing significantly longer hours (Royal College of Obstetricians and Gynecologists, 2020a).

By necessity, adaptations to services were made quickly, and some providers described the anxiety they’d experienced as they struggled to get familiar with new technologies: “For the first few weeks, we were constantly grappling with the technology and ringing the IT department”.

At the same time, in the immediate aftermath of the lockdown in March 2020 as services adjusted at speed, some health care workers found themselves unofficially working outside their remit and training. For example, a perinatal psychological practitioner in a secondary care mental health service found themselves supporting people around physical health issues because their clients were not receiving the care they needed from elsewhere. There were reports that some midwives had kept families on their caseload beyond day 10 and for up to six weeks because they were concerned about the baby (e.g. because it hadn’t regained its birth weight) and the family was not going to be seen by a health visitor. Likewise, increased demand is resulting in some third sector providers working outside their remit, for example supporting people with severe depression despite their services being designed to support people with mild to moderate depression.

Health visitors report that the increased pressure under which people have been working has resulted in higher sickness absence and people leaving the profession.

In ‘normal’ times, the course of midwives’ work involves psychological challenges. They will witness traumatic births and a significant proportion will suffer symptoms of secondary psychological trauma as a result, leading to an increased risk of developing PTSD (see Kirkman *et al.*, 2019 and Patterson, 2019). We were told that the restrictions have also placed additional psychological burdens on midwives, who have to “...juggle the asks of the partners and of the family ...whilst looking after the woman... and also trying to look after themselves...”. The restrictions have often resulted in distress for women and their partners, and midwives have frequently borne the brunt of this.

Peer support services highlighted the fact that peer supporters have lived mental health experience themselves. During the pandemic, they’ve been supporting women with greater complexity and exacerbation of conditions than normal, while working from home, home-schooling and dealing with their own anxieties around the pandemic.

One VCS peer support provider has been unable to train new volunteers, because it is not possible for them to shadow existing volunteers.

With so much remote working, it is challenging for workers to maintain relationships across services and such relationships are crucial for effective referrals, signposting, information sharing and collaboration.

## What’s worked well and less well?

### Redeployment of key staff

There was general agreement that the redeployment of health visitors was a mistake, and that health visiting is an essential frontline service which should be protected. The Institute of Health Visiting campaigned against the redeployment of health visitors. NHS England and Public Health England have now returned health visitors to their roles and stated that they should not be redeployed in future.

### Collaboration

The challenges of this time have made strategic collaboration and joining up pathways between

the voluntary sector, health visitors, midwives, GPs and specialist perinatal community mental health teams even more important than usual. Such cross-agency working helps to prevent mothers falling through gaps in provision.

One third sector provider reported that it has facilitated referrals to community specialist perinatal mental health teams. A mother may not meet the threshold for the specialist perinatal mental health team to act on a referral but, based on a more in-depth knowledge of the mother's situation, the provider might make the case at a multi-disciplinary team meeting for that referral to be followed up.

A rural-based perinatal team reported that communication with maternity, health visiting and mother and baby units had "hugely improved" as a result of utilising digital platforms in place of face-to-face meetings.

As a result of the discussion in one of our events, a provider created a Facebook Group to act as a forum for statutory and VCS sector perinatal mental health support providers to connect with each other, immediately attracting dozens of members.

### **Effective distance provision**

Providers had to react fast to adapt face-to-face services to other forms of delivery, and have continued to adapt as they learn what works well and less well.

Distance provision can never fully replace face-to-face interaction. Building a relationship between professionals and service users takes work at the best of times and working remotely makes this harder. Health visitors, for example, report that they don't have enough time to do so effectively, particularly as they are dealing with more safeguarding and domestic abuse cases.

Some groups are more likely to engage with drop-in services than with services requiring them to plan in advance. For example, we were told of a perinatal drop-in wellbeing hub, unable to operate during the pandemic, which usually attracts attendance from young mothers who don't engage with many other services. These mums having to make a phone

appointment to access the service has resulted in fewer of them making contact. Similarly, in normal times, children's centres reach a lot of vulnerable families.

Crèche support for face-to-face activities both enables the provider to work directly with the children and gives mothers time to focus on themselves and their wellbeing, while confident their child is being well looked after. Naturally, this isn't possible with distance provision.

Further, while specific treatments may be evidence-based, virtual delivery may not have been robustly assessed. Thus their effectiveness when delivered in this way is unclear.

Third sector providers reported hearing of some inappropriate use of distance provision, particularly with postnatal care, for example mothers with infected stitches being asked to send photos to their GPs, which the mothers found degrading.

However, many providers had been surprised by how positively remote support had been received by clients and how easily clients had adjusted to it.

Some providers found that many women welcomed being able to attend sessions without travelling (particularly if they lived a long way from a session, had mobility issues or had mental health issues that impacted on them leaving the home). Some peer support workers have found that some (though not all) women prefer the relative anonymity of a phone call and are more likely to open up as a result. Third sector providers and some statutory providers reported that non-attendance was lower for phone and video consultations than for face-to-face appointments, particularly for specific groups such as under-25s.

Providers delivering video interactive guidance for attachment therapy<sup>3</sup> were among those pleasantly surprised by the effectiveness of the medium. One reported that it was more effective delivered remotely because it felt less intrusive to mothers. As a result, the provider was able to observe natural interactions between the mother and baby.

<sup>3</sup> Video feedback intervention through which a "guider" helps a client to enhance communication within relationships.

One provider reported that delivering gestational diabetes mellitus dietary education and support appointments virtually had proven to be as effective as face-to-face hospital appointments.

Some providers also found that lighter touch media were the most successful. Some women preferred phone consultations to video, finding it easier to put their phone on speaker than sit in front of a webcam. Shorter, more frequent contact can be more effective when working remotely. A shorter call daily or every other day sometimes worked better than a longer, weekly call.

One third sector provider reported that an evaluation of the impact of providing their services online had revealed similar outcomes to face-to-face provision. They were also pleased to find that women who initially met online had met up face-to-face over the summer (when restrictions were eased). Forming a support network in the local community is a key benefit of participating in perinatal support groups, so it was reassuring to find that mothers who'd participated by video were still able to do this.

Some third sector support providers had found ways that enabled mothers to connect with each other and make friends, while interacting online. For example, one had created successful WhatsApp groups, moderated by a staff member, to provide that opportunity for mums to share their feelings and have them normalised by their peers that they are missing out on face-to-face. Another had set up a closed Facebook Group for members of their support group and found that, when they arranged face-to-face meetups during the summer, women built on relationships they had formed online.

This latter provider had been successful in attracting providers of services such as gym classes for toddlers, creativity classes and music classes to offer free sessions to their mums through the Facebook Group (although this may have been a function of such services themselves experiencing reduced demand, which would suggest this will become harder to do as the economy recovers).

On the other hand, some statutory providers found that mothers treated phone or video appointments as less important than face-to-face appointments. They reported that non-attendance increased, and clients attended appointments while shopping and/or in the company of other people.

And some third sector providers reported reduced demand for online support groups in comparison with face-to-face groups, leading them to fear that they're missing a significant proportion of need, attracting only the more confident and proactive mothers. It is more difficult to provide support and handholding to encourage mothers to attend online groups.

Confidentiality can be compromised when people attend virtual sessions from home. Not everyone has space within their home where they can speak privately. One provider had supported women who wanted to keep their engagement with the service private from their family, by text message.

Providers were also concerned about lack of digital access acting as a barrier to participation. One third sector provider had heard of another that had secured funding to purchase dongles for distribution to women who lacked data for internet access and was looking into doing the same. A statutory provider had used core funding to purchase tablets to lend to clients, preloaded with data. It was suggested that women should be enabled to attend hospitals or outreach clinics to use WiFi to access support services.

### **Ongoing use of distance provision**

Providers were all keen to return to face-to-face delivery; however, many were also planning to continue to provide online services as part of a blended approach.

Providing services at a distance increased capacity, as workers did not have to travel to appointments. One statutory provider highlighted how the increased capacity due to providing services digitally had enabled them to meet targets they usually missed. This led them to suggest that they might use distance provision to respond when there's a

lack of capacity in the system. For example, when capacity was stretched, women who were classed as ‘routine’ might be phoned after a set period of time waiting to be seen.

Distance provision also enabled providers to reach new communities, including communities they’d struggled to engage in the past (such as young men, communities experiencing racial inequality, and women in supported accommodation). However, we were also told that women from some communities tended to find it more difficult to talk about mental health, and virtual communication may exacerbate that. Some professionals (such as midwives) felt face-to-face communication was better in such cases.

One third sector provider had moved from being a sub-regional provider to operating nationally and intended to continue to serve the whole country. In the future, they will primarily deliver services online, with face-to-face work being a secondary part of their offering. This is a significant strategic redirection and they have recruited new trustees and are developing new funding streams.

Another had been planning to expand into a rural area and now intended to do so by providing online services rather than seeking premises and a local workforce. One example was the Shropshire perinatal specialist team, which had previously been unable to offer group therapies due to:

- Rurality and access problems for women
- Inadequate premises
- Problems providing childcare
- Staff time.

All of these were solved by remote working and four different types of groupwork are now provided very successfully on an ongoing basis. They reported good outcomes and that their clients liked these offers. In addition, remote working has meant a gap in psychiatry has been filled, as they can be based anywhere. This has also allowed the recruitment of a junior doctor post as they can receive remote supervision.

Another provider found that digital provision enabled them to attract women living in

supported accommodation, a group they had struggled to engage in the past, to their parenting course. Because the women attended from their accommodation, support workers were able to help them to attend and engage. Based on this success, the provider plans to continue to serve this group in this way.

On the other hand, some statutory providers expressed a fear that their organisations would be motivated to continue with distance provision because of the lower costs, failing to fully take into account the drawbacks. While wanting to be as flexible as possible in the way they delivered services, providers were concerned about increasing safeguarding issues and that working digitally made it harder to identify risk.

### **Maximising opportunities for face-to-face contact**

Some providers had developed innovative services to enable them to bring mothers together within Covid-19 restrictions. For example, in some areas at certain times, groups of up to 15 (excluding babies) could meet so long as social distancing could be maintained and the meetup was organised through an official service. Providers had therefore organised activities such as Nature and Wellbeing Walks. However, some providers had decided against organising group activities to avoid the risk of infection or having to self-isolate, including to their (small) workforce. Others were prevented from providing face-to-face services by the risk assessments of the venues they would use.

Others had found ways to provide services face-to-face to the most vulnerable families and those without internet access. This has included outdoor play activities in gardens and parks, work on doorsteps supporting mothers to make phone calls to services, and delivering care packages containing small treats and luxuries.

There are confidentiality issues associated with visiting homes which some teams have addressed by not wearing uniforms or lanyards, arranging their time of arrival in advance and (not always successfully) seeking places they can go for a more private socially distanced conversation.

## Advocacy and information dissemination

In the context of a rapidly evolving situation, with rules, regulations and guidance frequently changing (often at short notice), women have found it difficult to access trustworthy information, often not knowing where to go for accurate updates.

Referral pathways haven't always been clear and it has not always been easy to find out which services are operating, or how. For example, women have been unsure who can visit them in Mother and Baby Units or at home, or when they can go on leave from a Mother and Baby Unit.

It seems that the main problem was not a lack of information. In fact, some providers reported that mothers were overwhelmed by information, particularly in the early stages of the pandemic. Rather, it can be unclear where to go for what information and how trustworthy various sources are.

While many health visiting services quickly set up helplines, video conferencing services etc, these services varied in terms of how well they communicated the best ways for service users to make contact.

Many mothers partially plugged the gap by accessing information via social media which, while sometimes powerful, is an imperfect medium containing much misinformation (and even disinformation) presenting challenges about knowing what sources to trust.

The VCS' signposting and advocacy roles have been particularly important during this period. For example, Bristol and South Gloucestershire CCG funded voluntary groups, including The Bluebell Trust, to develop a website to help parents access mental health services and information from the Royal Colleges. Many organisations have used social media to disseminate information to, and connect with, families. For example, Action on Postpartum Psychosis developed a social media campaign to help families identify the signs and symptoms of postpartum psychosis and explain how to seek help.

Participants made recommendations for ensuring that mothers are aware of services and how to access them. The best places to display information changed as a result of services closing during lockdown. It became important to display information in shops, for example, rather than GP surgeries and children's centres. They also stressed the importance of displaying information in appropriate languages and working in partnership with agencies that work with particular communities. Peer support can help services reach parents who might not present to professionals.

## Provision of additional, responsive services

As described earlier, many providers, particularly third sector providers, had sought to be as flexible as possible, swiftly developing new services to address gaps in provision and the additional needs caused by the situation.

## Looking after the workforce

Several providers talked about the additional stresses on the perinatal mental health workforce: both from the point of view of the workers themselves; and in terms of the impact of workers being under stress on the quality of care provided. They suggested that it is important to learn lessons about recognising the stress the workforce is under at a time of crisis, and looking after the workforce, including through virtual team meetings.

## Future planning

It is essential that guidance for providers, including national guidance for statutory providers, is informed by the experiences of women and their partners during this crisis.

The Institute for Health Visiting (IHV) highlights that health visiting was scaled back despite the World Health Organization (2020b) warning that the secondary impact of lockdown conditions could lead to increased cases of domestic violence and abuse, non-accidental injuries, mental health problems and poverty. The IHV argues that this secondary impact posed a

greater threat to children than the virus itself and, therefore, services should have been enhanced rather than depleted.

It is the view of the IHV that health visitors should not have been redeployed. Whilst their nursing and leadership skills were welcomed by other sectors in their redeployed roles, their public health skills were most needed to support children and families. Following extensive lobbying from the Institute for Health Visiting, other national bodies, researchers and parents, the Chief Nurses at NHS England and Public Health England, alongside the Local Government Association, published a briefing and open letter on 7 October stating that:

*“professionals supporting children and families, such as health visitors, school nurses, designated safeguarding officers and nurses supporting children with special educational needs should not be redeployed to other services and should be supported to provide services through pregnancy, early years (0-19) and to the most vulnerable families.”* (Public Health England *et al.*, 2020)

The Royal College of Obstetricians and Gynaecologists has called for NHS trusts and Health Boards to ensure that maternity staff are not redeployed (2020b). It has identified key principles for ongoing service planning in the second wave of Covid-19, including the following:

- Day assessment and triage services where women can attend for emergency review should be maintained, and maternity staff should actively encourage women to attend if they have concerns about their or their baby’s wellbeing
- All places of birth, including midwifery-led units and support for birth at home, should be maintained as far as possible in the context of local staffing and service capacity
- NICE-recommended schedules of antenatal and postnatal care should be offered in full, wherever possible (Royal College of Obstetricians and Gynaecologists, 2020b).

The Royal College of Obstetricians and Gynaecologists continues to liaise with the Government to request support, and the provision of appropriate occupational health guidance, for pregnant women working in a variety of settings (2020b). It states:

*“Perinatal mental health care is an essential part of the maternity care pathway, and this should be recognised in planning for the ongoing response to the pandemic. [We] therefore support the MMHA calls for decision-makers to learn from these findings and plan for the mental as well as physical health needs of women and their families, including protecting the perinatal mental health workforce.”*

Covid-19 restrictions have accelerated changes in the delivery of remote services using digital technologies. Little is currently known about safe and effective digital practice and there is little or no evidence-based professional guidance. The Institute of Health Visiting is seeking funding to investigate the effectiveness of providing remote digital services, including its impact on services for the most vulnerable families and identification of safeguarding concerns.

Whilst evidence was more limited, the reported impact of the pandemic on partners underlines the need for a whole-family approach to maternity, through antenatal appointments, midwifery check-ups, birth and postnatally (including health visiting).

## 6. Discussion

Service provision for pregnant women, new mothers and their families was not sufficient prior to this, the most seismic of social crises in living memory. Evidence presented to the review revealed that services such as health visiting had suffered cuts as a result of austerity measures, and were therefore under pressure in the few years leading up to the pandemic. These cuts had impacted both the public and voluntary and community sector (VCS).

Despite investment in specialist perinatal mental health services, coverage across all four UK nations is not the same, with women having more or less access depending on the nation, and part of the nation, in which they live. We can reasonably conclude that this had been short sighted given that the cost to the UK of poor maternal mental health is estimated at £8.1 billion per each year's birth cohort (Bauer *et al.*, 2014); but also commend our national Governments for their more recent recognition of this which has led to investment in new services, for example England's new specialist perinatal mental health services, now with funding to cover all of England.

It is also commendable that pregnant women and new mothers were identified as a vulnerable and priority group early in this crisis. During 'normal times', as many as two in every ten women giving birth will go on to struggle with their mental wellbeing, and a minority of these will have very severe and even life-threatening difficulties. The repercussions of these go beyond the women themselves and can be measured in impact on their families, relationships and in the longer-term life outcomes of their children.

The case for intervention and accessible support is clear. It was reasonable to predict at the outset of this crisis in March 2020 that women experiencing pregnancy, birth and the mothering of infants and children would likely suffer more during a crisis that restricts contact of all sorts and access to support.

However, whilst these women were identified as a priority and the heightened risk was recognised, and whilst many services introduced innovations to maintain and even increase their contacts, the evidence presented to this review indicates the net result was a decrease in services available to women and their families. In the public sector some staff were redeployed to other health services, others saw increases in their caseloads, less experienced staff were deployed in some cases, and face-to-face contacts reduced (and it took some services more time to develop virtual alternatives). There is some limited evidence (see appendix A) that there was a dramatic drop in open referrals to specialist perinatal mental health services; these would be for women at risk of the most severe mental illness.

In the VCS demand increased, but not all services could respond to meet this demand. Many VCS services experienced their own resource crisis, through furloughing, ill-health and the need for staff to fill gaps in their childcare, amongst other reasons. All this has happened at a time when our research indicates an increased need for monitoring the mental health of pregnant women and new mothers.

It is not just the support from professionals that has been impacted by the crisis; importantly, informal support has also been markedly reduced. Much of what would have been crucial but normal informal support for pregnant women and new mothers became unlawful. The restrictions enforced isolation to a great degree, as did the anxiety of women and their families over catching the virus. For significant periods since March 2020, across our four nations, new mothers have been unable to meet up with other new mothers, as they would have done before, or even with relatives and friends. Partners have not been able to be present at births. The opportunity for moments away from mothering have been dramatically reduced. Our contributors commented on the impact this has had on women, families and children.

The evidence presented to this review highlights that pregnant women and new mothers have faced greater challenges to their mental wellbeing for a variety of reasons; there is clear evidence that more women are struggling. Our evidence suggests that some groups of women have suffered more during the crisis, such as women of colour, those from socially deprived communities (in which people of colour will be overrepresented), those with pre-existing mental health conditions and those living with domestic violence. Women and families of colour working over the crisis felt markedly more exposed and less protected than other communities over the crisis.

Our review received evidence of higher levels of anxiety and depression during the crisis. We do not have clear evidence as to the impact on women with histories of more severe mental illness, although we know there was some reduction in service to this group. We are also still quite 'close' to the crisis, and insufficient time has passed to ascertain with any certainty the longer-term impacts. However, our contributors felt strongly that there will be a longer-term negative legacy and that some resource needs to be directed to tackling this. Perhaps the continued duration of the crisis, and of significant restrictions on social and family life, makes the longer-term negative legacy all the more likely.

The innovations that both VCS and public sectors developed to respond to the crisis (such as various online and virtual initiatives) have been impressive and have doubtless proven a lifeline to many women and their families. Developing these has at times been challenging, and acquiring equipment, training staff and learning how to manage issues such as safeguarding and data protection have all been part of this.

Some services reported that virtual communication has allowed them to access communities they could not before, provide interventions that were previously difficult to offer, and recruit staff when factors such as rurality had previously been a barrier. Interagency meetings (critical to effective information exchange) had become easier to organise via virtual platforms and saved valuable time. With regard to this point, interagency working is significantly improved by co-location, even if partial. We do not know if virtual communication can impede or enhance this, and this is worth exploration.

Our contributors all recognised the significant contribution of virtual communication as temporary alternative means of maintaining contact, and also as adjuncts to actual face-to-face contact. Face-to-face contact is seen as vital, especially with those at greater risk or where virtual communication makes assessment more difficult. Additionally, not all pregnant women and new mothers have adequate access to digital technology, and it is critical to factor in how to support people living in digital poverty.

Sadly, we are not reporting on a historical event. At the time of writing, with new variants of the virus seeming to cause greater infection rates, all four nations of the UK have reintroduced the highest level of restrictions with even stricter restrictions being considered. The impact of each lockdown will be with us for years to come. This crisis is therefore current and ongoing, with the risks posed to perinatal mental health urgently in need of current and ongoing attention.

## 7. Our recommendations for action

The pandemic has created a mental health crisis for many women in pregnancy and after the birth of their child. Women have experienced a combination of lockdown, economic uncertainty, job insecurity, and the impact of the virus itself, coupled with a reduced ability to gain access to perinatal health services and mental health services. This is likely to have long-term consequences for women and their families as well as for health services.

That's why we are making the following eight urgent recommendations for action:

1. **Assessing the true level of demand.** We call on the Department of Health and Social Care in England, and the equivalent bodies in the devolved nations, to conduct an immediate assessment of the level of need for perinatal mental health services in light of the impact of the pandemic. Previous assumptions will need to be updated to reflect higher levels of need as a consequence of the crisis. This is essential to get the right services and workforce in the right places as soon as possible.
2. **We want to future-proof perinatal mental health services against future pandemics or similar public health crises.** We are calling on the UK Government and devolved assemblies to guarantee a minimum high standard of mental health care and support for pregnant women and mothers of young infants. We want to ensure that perinatal mental health staff numbers are maintained, and where staff redeployment proves necessary in a crisis, mental health services must be maintained.
3. **We need up-to-date data to understand the changing picture.** NHS Digital and equivalent bodies in each of the devolved nations should collect and publish routine data on the mental and physical health of women during the perinatal period. This should include data on the uptake of perinatal mental health services, on deaths from all causes, and on hospital admissions. Data must include robust monitoring across equality groups to identify inequalities in prevalence, experience and outcomes.
4. **We need to tackle racial discrimination within health systems and adverse outcomes for people of colour.** The NHS in all four nations needs to address the disparity in maternal mental health outcomes caused by the crisis, and by longer-term issues, for women of colour. In England, this should be included within the Advancing Mental Health Equalities strategy and the Patient and Carer Race Equality Framework.
5. **We need better research.** We are calling on those funding and conducting research across the UK to prioritise understanding the longer-term emotional and psychological impacts of the pandemic on young families. This might include research with women with existing mental health difficulties, and groups that have been particularly affected by the pandemic. We need to hear from particularly vulnerable groups of women, and groups whose voices are seldom heard. We recommend research on the impact of women's mental wellbeing on their partners and infants, and research on partners' mental wellbeing and the impact this can have on women.

6. **We need to understand the impact of ‘remote’ mental health care.** Where face-to-face services have been replaced by remote services, we must understand how they work and whether there is an impact on quality, choice, patient satisfaction and most of all whether they help people with their mental health. We are calling on the NHS to fund new research, to ensure those women who do not have access to digital technology get the support they need, and to make sure digital options are not a way to save money at the expense of face-to-face consultations and therapies.
7. **Government and NHS must recognise the importance of voluntary and community organisations.** NHS organisations commissioning mental health services must recognise and value the role of voluntary and community organisations in meeting women’s mental health needs during the perinatal period. We are recommending that funding should extend beyond short-term support for projects and initiatives, to provide organisations working in communities with stable long-term support and help with core costs and adaptations during crises.
8. **We must support the mental health of all health and care staff.** NHS employers in all parts of the UK and in every organisation must support the mental health and emotional wellbeing of staff working with women and families during the perinatal period, recognising the risk of exhaustion, anxiety, depression and post-traumatic stress disorder (PTSD) created during the pandemic.

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## Appendix A: NHS England perinatal mental health figures

Centre for Mental Health reviewed the available data sources on perinatal mental health across the four nations. There were no free-to-access and open-to-public datasets for Scotland, Wales and Northern Ireland. Only England has this data available to the public. The data covering the first lockdown was published in December 2020. This provides a very limited picture.

### Data accessed

NHS England publish Monthly Mental Health Statistics<sup>4</sup> datasets that contain information on the number of people accessing services. For this report, four variables were used drawn from two dataset from these statistics. Specifically, these were the 'Mental Health Services Data Sets Monthly' and 'Women in contact with mental health services who were new or expectant mothers' datasets<sup>5</sup>.

### Mothers in the perinatal period

NHS England report an estimated figure on the total number of new and expectant mothers who are in the perinatal period (see Appendix B for full definition). Broadly speaking, the start of the perinatal period is the date of identification of pregnancy by a health care professional and the end date is twelve months following the live delivery. This will not capture all pregnancies (as miscarriage is not included), nor all new and expectant mothers as, for instance, those women who do not engage with NHS-funded maternity services will not be included. However, NHS England suggest that the gaps should be small.

On average, the number of mothers aged 16 or over who were in the perinatal period was 1,534,172 between January 2018 and September 2020. Overall, the number of mothers in the perinatal period has been relatively stable, with the greatest variation seen for the periods April 2019 to March 2020, and January 2018 to December 2018.

### Secondary mental health

This section examines published data on the number of new and expectant mothers aged 16 or over in the perinatal period who have a mental health referral open to a secondary mental health service (see Appendix B for full definition). As with the previous data, the reporting periods are for 12 months published quarterly.

Since the period January 2018 to December 2018, there has been a gradual increase in the number of open referrals to secondary mental health services, an average of 72,500 between January 2018 and September 2020. This equates to a 17.5% increase from the initial period of January 2018 to December 2018, to the latest published data for the period October 2019 to September 2020. This covers a period in which there has been a growth in specialist perinatal mental health services across England.

### Specialist perinatal mental health services

As part of the Monthly Mental Health Statistics release, data is published on open referrals to and contacts with perinatal mental health teams<sup>6</sup> in England. Mothers in the perinatal period who have an open referral had steadily increased from October 2019 to January 2020. Open referrals began to reduce from February 2020, with a large fall from March to April 2020. The total number of open referrals has gradually increased since April 2020 up to September 2020, which is returning to levels seen prior to the reduction. In percentage terms, there was a 14.4% fall in open referrals from January 2020 to April 2020.

<sup>4</sup> See <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics>

<sup>5</sup> For example, September publication: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/performance-september-provisional-october-2020>

<sup>6</sup> Service team type 'C02' defined as 'Specialist Perinatal Mental Health Service'.

**Figure A1. Open referrals to perinatal mental health teams at the end of the reporting period**

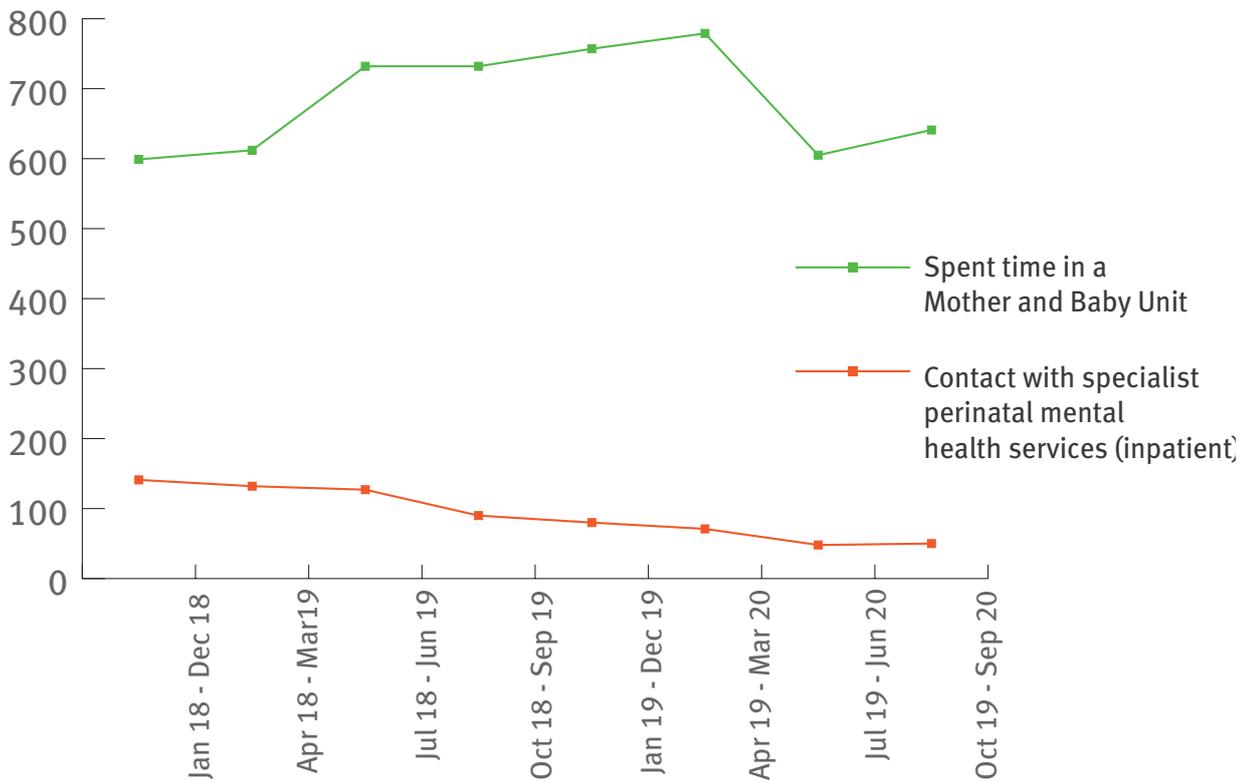


NB. each reporting period runs from the first to the last day of the month stated.

The number of attended contacts with a specialist perinatal mental health team between October 2019 and September 2020 are displayed in Figure A2 overleaf. Overall, there is a general upward trend in the total number of monthly attended contacts with mothers in the perinatal period. Since the beginning of the pandemic in March 2020, the number of attended contacts has exceeded 29,000, which had only occurred in January 2020 for the period displayed in Figure A4. This also coincides with a fall in the total number of open referrals to specialist perinatal mental health services displayed previously in Figure A1.

Figures suggest that the use of inpatient admissions to specialist perinatal mental health services has steadily been declining during a period of steady increase in the number of mothers who have spent time in a Mother and Baby Unit. There appears to have been a drop in the number of mothers spending time in a Mother and Baby Unit in the first reporting period likely to have been affected by the pandemic.

**Figure A2. Contacts with specialist perinatal MH service (inpatient only) or Mother and Baby Unit**



NB. each reporting period is for 12-months from the start of the month listed in the figure. This means that each quarter the 12-month period shifts ahead by 3 months.

It is not known whether contacts during the first lockdown period included virtual and telephone contacts. The only finding that appears to show an impact of Covid-19 and the restrictions is the drop in referrals/open referrals (see Figure A1) around April 2020, coinciding with the early period of the first lockdown. Referrals begin to rise immediately after this but had not quite recovered to peak levels (January and February 2020) by September referrals, the last point we have data for. However, the number of new and expectant mothers in the perinatal period who are in contact with specialist perinatal mental health services has seen a steady increase when observing the 12-monthly reporting period, which are less likely to be affected by sudden fluctuations.

In addition, whilst the number of open referrals decreased from January 2020, an increase in the number of attended contacts shows an upward trend from February through to the last monthly reporting period of September 2020. One explanation for this might be the move by health care providers away from face-to-face contacts to alternative methods of communication such as videoconferencing for the majority of appointments, meaning that these could be more frequent and possibly shorter in duration. However, as previously stated, the data does not distinguish between virtual and face-to-face contacts.

## Appendix B: Notes and definitions from ‘Women in contact with mental health services who were new or expectant mothers’ dataset

### The perinatal period

The perinatal period can be defined in a number of ways. This analysis uses a definition provided by NHS England which is detailed below.

This approach aims to identify all women who are in the mental health perinatal period and are in touch with secondary mental health services in scope of the Mental Health Services Data Sets (MHSDS), including those who do not present to English maternity services.

From this the definition, the perinatal period is a period of time that runs from:

- The date of identification of pregnancy by health or community services, or
- The patient stated date of birth of the baby where:
  - The woman’s pregnancy has not previously been identified by health or community services and the woman has had a live birth in the previous twelve months, or
  - The woman has taken over parental responsibility but is not the birth mother and the baby is under twelve months old.

to:

- Twelve months following the live delivery, or
- The date that the woman no longer has the baby in her own care in this twelve month period, or
- Date of loss of the foetus/baby that is under twelve months old (any cause: abortion, miscarriage, still birth or death following live birth)
- In each case:
  - as identified by health or community services, or
  - as stated by the patient.

In this analysis it has not been possible to implement this definition fully. The gap in coverage should be small and covers those women who do not engage with NHS-funded maternity services, who enter the country during the perinatal period, or take parental responsibility for a child under twelve months of age. This gap will be considered following this analysis and options for including other data sources explored if required. Pregnancies which had no recorded date of delivery or estimated delivery date have been excluded from the analysis. The numbers of these are low and are due to data quality issues. Using this definition the following dates have been derived for each pregnancy using linked MHSDS/Maternity Services Data Sets (MSDS) information:

**Perinatal start date:** this is the date of identification of pregnancy by health or community services. The start date has been taken as the date of the initial booking appointment in the MSDS regardless of pregnancy outcome.

**Perinatal end date:** this has been defined as twelve months after the date of live delivery in the MSDS. If the birth date was not recorded then the end date has been taken as twelve months after the estimated date of delivery (as recorded at the booking appointment). If the pregnancy did not continue to term for any cause then the perinatal period ends at the date of loss of the foetus/baby that is under twelve months old.

## Identifying mental health services

The MHSDS covers information on people in contact with NHS funded secondary mental health, learning disabilities and autism services. In the analysis included in this report we have only included those people who have been in contact with mental health services in order to more accurately identify people who are in treatment for a mental health problem during the perinatal period. Some people in contact with services in scope for the MHSDS may solely be in contact with learning disabilities or autism services. These people have been excluded from the analysis included in this report.

## Identifying women in scope for specialist perinatal mental health services

NHS Digital have been working with stakeholders within NHS England to understand how to identify those people in scope for specialist perinatal mental health services. In applying guidance issued by the National Institute for Health and Care Excellence (NICE), the scope of this has been limited to women aged 16 or over who are in the perinatal period and in contact with secondary mental health services. Other treatment interventions may be appropriate for women outside of this group.

## Maternal mental health during a pandemic

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